

**A Health Maintenance Organization
with a point of service product**

Serving: Central, Eastern South Dakota and counties surrounding the Rapid City area.

Enrollment in this Plan is limited. You must live in our Geographic service area to enroll. See pages 6-7 for requirements.

Sioux Valley Health Plan and Sioux Valley Health Plan of Minnesota Commercial HMO products received NCQA New Health Plan Accreditation on July 28, 2000 effective through July 28, 2003.



NCQA's New Health Plan Accreditation Program applies to health plans that are less than two years old. The program is distinct from NCQA's MCO Accreditation Program.

Enrollment codes for this Plan:

**AU1 Self Only
AU2 Self and Family**

Special notice: This Plan is offered for the first time under the Federal Employees Health Benefits Program during the 2001 Open Season.



Authorized for distribution by the:



**United States
Office of Personnel Management**
Retirement and Insurance Service
<http://www.opm.gov/insure>



Table of Contents

Introduction	4
Plain Language	4
Inspector General Advisory	4
Section 1. Facts about this HMO plan	6
We also have point-of-service (POS) benefits	6
How we pay providers	6
Your Rights	6
Service Area	6
Section 2. We are a new plan	8
Section 3. How you get care	9
Identification cards	9
Where you get covered care	9
• Plan providers	9
• Plan facilities	9
What you must do to get covered care	9
• Primary care	9
• Specialty care	9
• Hospital care	10
Circumstances beyond our control	10
Services requiring our prior approval	10
Section 4. Your costs for covered services	13
• Copayments	13
• Deductible	13
• Coinsurance	13
Your out-of-pocket maximum	13
Section 5. Benefits	14
Overview	14
(a) Medical services and supplies provided by physicians and other health care professionals	15
(b) Surgical and anesthesia services provided by physicians and other health care professionals	23
(c) Services provided by a hospital or other facility, and ambulance services	26
(d) Emergency services/accidents	28
(e) Mental health and substance abuse benefits	30
(f) Prescription drug benefits	32
(g) Special features	34
• 24 Hour Nurse Line	

• Services for deaf and hearing impaired	
• High risk pregnancies	
• Centers of Excellence for transplants	
(h) Dental benefits.....	35
(i) Point of service product.....	36
Section 6. General exclusions -- things we don't cover.....	39
Section 7. Filing a claim for covered services	40
Section 8. The disputed claims process	41
Section 9. Coordinating benefits with other coverage	43
When you have...	
• Other health coverage.....	43
• Original Medicare.....	43
• Medicare managed care plan	45
TRICARE/Workers' Compensation/Medicaid	45
Other Government agencies.....	46
When others are responsible for injuries.....	46
Section 10. Definitions of terms we use in this brochure.....	47
Section 11. FEHB facts	49
Coverage information.....	49
• No pre-existing condition limitation.....	49
• Where you get information about enrolling in the FEHB Program	49
• Types of coverage available for you and your family.....	49
• When benefits and premiums start.....	49
• Your medical and claims records are confidential.....	50
• When you retire	50
When you lose benefits	50
• When FEHB coverage ends.....	50
• Spouse equity coverage	50
• Temporary Continuation of Coverage (TCC).....	50
• Converting to individual coverage.....	51
• Getting a Certificate of Group Health Plan Coverage	51
Long term care insurance is coming later in 2002	52
Index.....	53
Summary of benefits.....	54
Rates	Back cover

Introduction

Sioux Valley Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110

This brochure describes the benefits of Sioux Valley Health Plan under our contract (CS 2443) with the Office of Personnel Management (OPM), as authorized by the Federal Employees Health Benefits law. This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled for Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2002, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2002, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

Teams of Government and health plans' staff worked on all FEHB brochures to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member; "we" means Sioux Valley Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the Office of Personnel Management, Office of Insurance Planning and Evaluation Division, 1900 E Street, NW Washington, DC 20415-3650.

Inspector General Advisory

Stop health care fraud!

Fraud increases the cost of health care for everyone. If you suspect that a physician, pharmacy, or hospital has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 605/328-6800 and explain the situation.
- If we do not resolve the issue, call or write

THE HEALTH CARE FRAUD HOTLINE
202/418-3300

The United States Office of Personnel Management
Office of the Inspector General Fraud Hotline
1900 E Street, NW, Room 6400
Washington, DC 20415

Penalties for Fraud

Anyone who falsifies a claim to obtain FEHB Program benefits can be prosecuted for fraud. Also, the Inspector General may investigate anyone who uses an ID card if the person tries to obtain services for someone who is not an eligible family member, or is no longer enrolled in the Plan and tries to obtain benefits. Your agency may also take administrative action against you.

Section 1. Facts about this HMO plan

This Plan is a health maintenance organization (HMO). To receive in-network benefit coverage, the Plan requires you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. You are encouraged to select a Sioux Valley Health Plan participating Primary Care Provider (PCP) to provide and coordinate your healthcare services. However, the Plan does not require that you select a PCP or that a PCP refer you for specialty care. You can self-refer yourself to a Sioux Valley Health Plan participating specialty provider at any time.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You only pay the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

We also have Point-of-Service (POS) benefits:

Our HMO offers Point-of-Service (POS) benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance or deductible (if applicable).

Your Rights

OPM requires that all FEHB Plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB website (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- Years in existence
- Profit status

If you want more information about us, call 1-800/752-5863, or write to Sioux Valley Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. You may also contact us by fax at 605/328-6812 or visit our website at www.siouxvalley.org.

Service Area

To enroll in this Plan, you must live in our Service Area. This is where our providers practice. Our service area is: Aurora, Beadle, Bennett, Bon Homme, Brookings, Brown, Brule, Buffalo, Butte, Campbell, Charles Mix, Clark, Clay, Codington, Davison, Day, Deuel, Douglas, Edmunds, Faulk, Grant, Gregory, Hamlin, Hand, Hanson, Hughes, Hutchinson, Hyde, Jerauld, Kingsbury, Lake, Lawrence, Lincoln, Lyman, Marshall, McCook, McPherson, Meade, Miner, Minnehaha, Moody, Potter, Roberts, Sanborn, Spink, Stanley, Sully, Todd, Tripp, Turner, Union, Walworth, and Yankton.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. We are a new plan

This Plan is new to the FEHB Program. We are being offered for the first time during the 2001 open season.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your Employee Express confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800/752-5863.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance, and you will not have to file claims. If you use our point-of-service program, you can also get care from non-Plan providers, or from participating providers without a required referral, but it will cost you more. You may also have to file your own claims.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to the NCQA national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our website.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our website.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member are encouraged, but not required, to select a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care. Primary care physicians are included in the Plan provider directory. You may choose the physician who best meets your needs.

- **Primary care**

Your primary care physician can be a family practitioner, internist, pediatrician, general practitioner or OB/GYN. Your primary care physician will provide most of your health care, or give you a referral to see a specialist.

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician may refer you to a specialist for needed care. However, you may also self-refer to Plan specialist providers. No referral is necessary.

Here are other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, you may directly access the specialist for needed services.
- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay at the in-network benefit level if you choose to see a specialist who does not participate with our Plan.

- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic or disabling condition and lose access to your specialist because we:
 - terminate our contract with your specialist for other than cause; or
 - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB Plan; or
 - reduce our service area and you enroll in another FEHB Plan,

you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us or, if we drop out of the Program, contact your new plan.

If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our Member Service department immediately at 605/328-6800 or 1-800/752-5863 (TTY 605/328-6869). If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

Services requiring our prior approval

Your primary care physician has authority to refer you for most services. For certain services, however, your physician must obtain approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice.

We call this review and approval process prior approval. You or your physician must obtain prior approval for the following services:

- Acute Inpatient Hospital Services;
- Maternity, Pregnancy, and Newborn Care;
- Inpatient Physician Services and Consultations;
- Outpatient Surgery not performed in a Physician’s office;
- Home Health Care and home IV therapy services;

- Skilled Nursing facility and sub-acute care;
- Non-Emergency Ambulance and Other Transportation Services;
- Mental Health Services;
- Chemical Dependency Services;
- Alcohol Treatment;
- Growth Hormone Therapy;
- Sexual Dysfunction Drug;
- Durable Medical Equipment and Prosthetic Device rentals or purchases over \$200;
- Outpatient Rehabilitative Therapy;
- Organ transplant services;
- Referrals to Non-Participating Providers which are recommended by Participating Providers, unless services are a result of a lack of appropriate access to Participating Providers, or unless you choose to accept Point of Service benefits.

A request for prior approval is required at least three (3) business days prior to the receipt of the Health Care Services listed above. Failure to do so will result in payment of benefits at the Out of Network Coverage level. In the event that health care services need to be provided within less than three (3) business days, Members should contact the Health Services Department at 605/328-6807 or 1-800/805-7938 to request an expedited review.

Prior approval is not required for Emergency Conditions. However, the Plan must be notified of an admission 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 authorized as an elective admission.

Prior approval Process

All requests for elective inpatient hospitalizations are to be made by the Physicians office at least three (3) days prior to the scheduled admission. Sioux Valley Health Plan's Health Services Department is available between the hours of 8:00a.m. and 5:00p.m. Central Time, Monday through Friday, by calling the Plan's toll-free number 1-800/805-7938.

The Health Services Department will review the Member profile information against standard criteria. A determination will be made by the Health Services Department within two (2) business days of the initial notification. The determination shall either be authorization of the requested service or additional review by the Health Plan Medical Director.

If the determination is to authorize the requested service, the attending practitioner and those Providers involved in the provision of the service shall be notified of the decision by telephone within *one (1)* business day of the initial determination. When the service is approved, the Health Services Department will assign an authorization/certification number. Written notification shall be sent to the attending practitioner, those Providers involved in the provision of the service and the Member within *three (3)* business days of the date of authorization.

When the request requires further review because a denial is being recommended by the Health Services staff, an intensified review will be performed by the Medical Director. If additional documentation is required, the Member, his or her representative, and/or the Provider shall be responsible for submitting any necessary information. A determination either authorizing or denying the request for services will be made within *two (2)* business days after the initial determination or, if additional information is necessary, within *two (2)* business days from the receipt of all necessary documentation. If information is not submitted within thirty (30) days, the Utilization Management (UM) record is closed and services will be denied. The attending practitioner, those Providers involved in the provision of the service and the Member shall be notified of the decision by telephone within *twenty-four (24) hours* of the determination. Those Providers involved in the provision of the service and the Member shall be provided with written notification of the decision within *two (2)* business days of the date of the determination.

If the decision is to deny a hospital or surgical facility admission or other service, it is the plan's policy to notify the attending physician and hospital of the determination by telephone and in writing within one (1) business day of the determination. The Member and those Providers who are involved in the provision of the service shall be informed of the reasons for the denial and

the Plan's appeal procedures. In addition, 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.

Section 4. Your costs for covered services

You must share the cost of some services. You are responsible for:

- **Copayments**

A copayment is a fixed amount of money you pay to provider, facility, pharmacy, etc., when you receive services.

Example: When you see your primary care physician you pay a copayment of \$10 per visit and when you go in the hospital, you pay \$100 per admission.

- **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them. Copayments do not count toward any deductible. Deductibles only apply when you use our Point of Services (POS) benefits.

The calendar year deductible for POS benefits is \$500 per individual. Under a family enrollment, the deductible is considered satisfied and benefits are payable for all family members when the combined covered expenses applied to the calendar year deductible for family members reaches \$1,000.

NOTE: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

And, if you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

- **Coinsurance**

Coinsurance is the percentage of our negotiated fee that you must pay for certain in-network and all out-of-network care. Coinsurance doesn't begin until you meet your deductible for out-of-network care (there is no deductible for in-network care).

Example: In our Plan, you pay 40% of our allowance for medical office visits when you receive services from a Non-Participating Provider or you pay 20% of our negotiated fee for durable medical equipment and orthopedic appliances received by in-network providers.

Your catastrophic protection out-of-pocket maximum for deductibles, coinsurance, and copayments

After your in-network copayments total \$1500 per person or \$3000 per family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs; and
- Physician office visits.
- Be sure to keep accurate records of your copayments, deductibles and coinsurance since you are responsible for informing us when you reach the maximum.

Section 5. Benefits – OVERVIEW

(See page 8 for how our benefits changed this year and page 15 for a benefits summary.)

NOTE: This benefits section is divided into subsections. Please read the important things you should keep in mind at the beginning of each subsection. Also read the General Exclusions in Section 6; they apply to the benefits in the following subsections. To obtain claims forms, claims filing advice, or more information about our benefits, contact us at 1-800/752-5863 (TTY at 605/328-6869).

(a) Medical services and supplies provided by physicians and other health care professionals.....	15-22
• Diagnostic and treatment services	• Speech therapy
• Lab, X-ray, and other diagnostic tests	• Hearing services (testing, treatment, and supplies)
• Preventive care, adult	• Vision services (testing, treatment, and supplies)
• Preventive care, children	• Foot care
• Maternity care	• Orthopedic and prosthetic devices
• Family planning	• Durable medical equipment (DME)
• Infertility services	• Home health services
• Allergy care	• Chiropractic
• Treatment therapies	• Alternative treatments
• Physical, cardiac and occupational therapies	• Educational classes and programs
(b) Surgical and anesthesia services provided by physicians and other health care professionals.....	23-25
• Surgical procedures	• Oral and maxillofacial surgery
• Reconstructive surgery	• Organ/tissue transplants
	• Anesthesia
(c) Services provided by a hospital or other facility, and ambulance services.....	26-27
• Inpatient hospital	• Extended care benefits/skilled nursing care facility benefits
• Outpatient hospital or ambulatory surgical center	• Hospice care
	• Ambulance
(d) Emergency services/accidents.....	28-29
• Medical emergency	• Ambulance
(e) Mental health and substance abuse benefits.....	30-31
(f) Prescription drug benefits.....	32-33
(g) Special features.....	34
• 24 Hour Nurse Line	
• Services for deaf and hearing impaired	
• High risk pregnancies	
• Centers of Excellence for transplants	
(h) Dental benefits.....	25
(i) Point of service benefits.....	36-38
Summary of benefits.....	55

Section 5 (a). Medical services and supplies provided by physicians and other health care professionals

**I
M
P
O
R
T
A
N
T**

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for In Network services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**I
M
P
O
R
T
A
N
T**

Benefit Description	You pay
Diagnostic and treatment services	
Professional services of physicians, nurse practitioners, and physician's assistants <ul style="list-style-type: none"> • In physician's office • In an urgent care center • Office medical consultations • Second surgical opinions 	\$10 per visit
Professional services of physicians, nurse practitioners, and physician's assistants <ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing
Home visits	Nothing
Lab, X-ray and other diagnostic tests	
Tests, such as: <ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine pap tests • Pathology • X-rays • Non-routine Mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG 	Nothing

Preventive care, adult	You Pay
Routine screenings, such as: <ul style="list-style-type: none"> • Total Blood Cholesterol – once every three years • Colorectal Cancer Screening, including: <ul style="list-style-type: none"> • Fecal occult blood test • Sigmoidoscopy, screening – every five years starting at age 50 • Prostate Specific Antigen (PSA test) – one annually for men age 40 and older • Colonoscopy – once every 5 years 	Nothing
Routine pap test NOTE: The office visit is covered if pap test is received on the same day; see <i>Diagnosis and Treatment</i> , above.	Nothing
Routine mammogram –covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing
<i>Not covered: Physical exams required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges.</i>
Routine immunizations, limited to: <ul style="list-style-type: none"> • Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under Childhood immunizations) • Influenza/Pneumococcal vaccines, annually, age 65 and over 	Nothing
Preventive care, children	
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing
<ul style="list-style-type: none"> • Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: <ul style="list-style-type: none"> – Eye exams through age 17 to determine the need for vision correction. – Ear exams through age 17 to determine the need for hearing correction – Examinations done on the day of immunizations (up to age 22) 	\$10 per visit

Maternity care	You pay
<p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>NOTE: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You need to pre-approve your normal delivery due to the inability to predict admission, obstetrical admissions shall be authorized when the pregnancy is confirmed. C-sections must be pre-approved as an elective admission. See page 11 for the pre-approval process. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). <p>NOTE: We encourage all members to participate in the Plan's Healthy Pregnancy Program; see <i>Special Features</i> Section.</p>	<p>Nothing</p>
<p><i>Not covered: Routine sonograms to determine fetal age, size or sex.</i></p>	<p><i>All charges.</i></p>
Family planning	
<p>A broad range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Voluntary Sterilization • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>NOTE: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$10 per visit 20% of charges per inpatient admission \$25 per outpatient surgery</p>
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling or testing.</i></p>	<p><i>All charges.</i></p>

Infertility services	You Pay
Diagnosis and treatment of infertility, such as: Artificial insemination: <ul style="list-style-type: none"> • <i>Intravaginal insemination (IVI)</i> • <i>Intracervical insemination (ICI)</i> • <i>Intrauterine insemination (IUI)</i> 	\$10 per visit 20% of charges per inpatient admission \$25 per outpatient surgery
<i>Not covered:</i> <ul style="list-style-type: none"> • <i>Assisted reproductive technology (ART) procedures, such as:</i> • <i>In vitro fertilization</i> • <i>Embryo transfer, gamete GIFT and zygote ZIFT</i> • <i>Zygote transfer</i> • <i>Services and supplies related to excluded ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> 	<i>All charges.</i>
Allergy care	
<ul style="list-style-type: none"> • Testing and treatment • Allergy injection 	\$10 per visit
Allergy serum	Nothing
<i>Not covered: provocative food testing and sublingual allergy desensitization.</i>	<i>All charges.</i>
Treatment therapies	
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy NOTE: High dose chemotherapy in association with autologous bone marrow transplants are limited to those transplants listed under Organ/Tissue Transplants on page 25. <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – Hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) NOTE: Growth hormone is covered under the medical benefit. NOTE: We will only cover GHT when we pre-authorize the treatment. Call 1-800/752-5863 for prior approval. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.	\$10 per visit

Physical, cardiac and occupational therapies	You Pay
<p>Coverage up to 2 consecutive months per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists • occupational therapists • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction. <p>NOTE: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury.</p>	<p>\$10 per outpatient visit Nothing per visit during covered inpatient admission</p>
<ul style="list-style-type: none"> • <i>Not covered:</i> • <i>long-term rehabilitative therapy</i> • <i>exercise programs</i> 	<p><i>All charges.</i></p>
Speech therapy	
<p>Coverage up to 2 consecutive months per condition by speech therapists</p>	<p>\$10 per outpatient visit Nothing per visit during covered inpatient admission</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Long term therapy</i> 	<p><i>All charges.</i></p>
Hearing services (testing, treatment, and supplies)	
<ul style="list-style-type: none"> • First hearing aid(s) (unilateral or bilateral, one time only), and testing and fitting of hearing aid(s) when necessitated by accidental injury only. <p>NOTE: Hearing services must be received within 6 months of injury.</p> <ul style="list-style-type: none"> • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	<p>\$10 per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>all other hearing testing</i> • <i>all other hearing aids</i> • <i>all other hearing supplies and services</i> 	<p><i>All charges.</i></p>
Vision services (testing, treatment, and supplies)	
<p>Eye glasses or one pair of contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</p>	<p>\$10 per visit</p>
<p>Eye exam to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>)</p>	<p>\$10 per visit</p>
Foot care	
<p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. See orthopedic and prosthetic devices for information on podiatric shoe inserts.</p>	<p>\$10 per visit</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> • <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery).</i> 	<p><i>All charges.</i></p>

Orthopedic and prosthetic devices	
<ul style="list-style-type: none"> • Artificial limbs and eyes; stump hose • Externally worn breast prostheses and surgical bras, including necessary replacements, following a mastectomy • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. NOTE: See 5(b) for coverage of the surgery to insert the device. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. 	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>orthopedic and corrective shoes</i> • <i>arch supports</i> • <i>foot orthotics</i> • <i>heel pads and heel cups</i> • <i>lumbosacral supports</i> • <i>corsets, trusses, elastic stockings, support hose, and other supportive devices</i> • <i>prosthetic replacements provided less than 3 years after the last one we provided.</i> 	<i>All charges.</i>

Durable medical equipment (DME)	You Pay
<p>Rental or purchase, at our option, including repairs (repairs are limited to \$750 allowable charges per year) and adjustments, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment. Under this benefit, we also cover:</p> <ul style="list-style-type: none"> • standard hospital beds; • standard wheelchairs; • crutches; • walkers; • canes; • diabetes supplies including blood glucose monitors and insulin pumps; • spacers • initial casts, braces, and/or slings provided on day of treatment; • air compressor • pressure pads, mattresses, and decubitus care equipment; • apnea monitor; • sleeve compression; • home intravenous therapy supplies; • commodes; • compression hose <p>NOTE: We will cover motorized wheelchairs and electric beds up to, but not to exceed, the cost of standard wheelchairs or standard hospital beds. Call us at 605/328-6807 or toll free at 1-800/805-7938 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>The remaining charges of a motorized wheelchair after the Plan contributes the cost of a standard wheelchair to the purchase</i> • <i>Medical supplies/equipment that can be purchased over-the-counter</i> • <i>Environmental control equipment</i> • <i>Household equipment/fixtures</i> • <i>Convenience items</i> • <i>Self-help items</i> • <i>Educational equipment</i> 	<i>All charges.</i>
Home health services	
<ul style="list-style-type: none"> • Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. 	Nothing

Home health services (continued)	You pay
Not covered: <ul style="list-style-type: none"> • Nursing care requested by, or for the convenience of, the patient or the patient's family; • Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative. 	<i>All charges.</i>
Chiropractic	
<ul style="list-style-type: none"> • Manipulation of the spine and extremities. • Adjunctive procedures such as ultrasound, electrical muscle stimulation, vibratory therapy, and cold pack application. NOTE: Office visits are limited to 20 visits per calendar year.	\$10 per visit
<i>Not covered: Vitamins, minerals, therabands, cervical pillows and traction services.</i>	<i>All charges.</i>
Alternative treatments	
<i>Acupuncture by a doctor of medicine or osteopathy for anesthesia pain relief.</i>	\$10 per visit
Not covered: <ul style="list-style-type: none"> • naturopathic services • hypnotherapy • biofeedback 	<i>All charges.</i>
Educational classes and programs	
Coverage is limited to: <ul style="list-style-type: none"> • Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as drugs • Diabetes self-management 	Nothing

Section 5 (b). Surgical and anesthesia services provided by physicians and other health care professionals

**I
M
P
O
R
T
A
N
T**

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care.
- We have no calendar year deductible for In Network services.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION OF SOME SURGICAL PROCEDURES.** Please refer to the precertification information shown in Section 3 to be sure which services require precertification and identify which surgeries require precertification.

**I
M
P
O
R
T
A
N
T**

Benefit Description	You pay
Surgical procedures	
<p>A comprehensive range of services, such as:</p> <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see reconstructive surgery) • Surgical treatment of morbid obesity -- a condition in which an individual weighs 100 pounds or 100% over his or her normal weight according to current underwriting standards; eligible members must be age 18 or over. • Insertion of internal prosthetic devices. See 5(a) – Orthopedic and prosthetic devices for device coverage information. • Voluntary sterilization • Treatment of burns <p>NOTE: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p>	<p>\$10 per office visit \$100 per inpatient surgery or service \$25 per outpatient surgery or service</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> • <i>Routine treatment of conditions of the foot; see Foot care.</i> 	<p><i>All charges.</i></p>

Reconstructive surgery	You pay
<ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities; cleft lip; cleft palate; birth marks; webbed fingers; and webbed toes. • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance on the other breast; - treatment of any physical complications, such as lymphedemas; - breast prostheses and surgical bras and replacements (see <i>Prosthetic devices</i>) <p>NOTE: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.</p>	<p>\$10 per office visit \$100 per inpatient surgery or service \$25 per outpatient surgery or service</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, except repair of accidental injury.</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>
Oral and maxillofacial surgery	
<p>Oral surgical procedures, limited to:</p> <ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; and • Other surgical procedures that do not involve the teeth or their supporting structures. 	<p>\$10 per office visit \$100 per inpatient surgery or service \$25 per outpatient surgery or service</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 	<p><i>All charges.</i></p>

Organ/tissue transplants	You pay
<p>Limited to:</p> <ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/Pancreas • Liver • Lung: Single –Double • Pancreas • Allogeneic (donor) bone marrow transplants • Autologous bone marrow transplants (autologous stem cell and peripheral stem cell support) for the following conditions: acute lymphocytic or non-lymphocytic leukemia; advanced Hodgkin's lymphoma; advanced non-Hodgkin's lymphoma; advanced neuroblastoma; breast cancer; multiple myeloma; epithelial ovarian cancer; and testicular, mediastinal, retroperitoneal and ovarian germ cell tumors • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas <p>Limited Benefits - Treatment for breast cancer, multiple myeloma, and epithelial ovarian cancer may be provided in an NCI- or NIH-approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.</p> <p>NOTE: We cover related medical and hospital expenses of the donor when we cover the recipient. All transplants must be provided at Plan participating Center of Excellence facilities.</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> 	<p><i>All charges.</i></p>
Anesthesia	
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital (inpatient) 	<p>Nothing</p>
<p>Professional services provided in –</p> <ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	<p>Nothing</p>

**Section 5 (c). Services provided by a hospital or other facility,
and ambulance services**

**I
M
P
O
R
T
A
N
T**

Here are some important things to remember about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are covered in Sections 5(a) or (b).
- **YOU OR YOUR PHYSICIAN MUST GET PRECERTIFICATION OF NON-EMERGENCY HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require precertification.

**I
M
P
O
R
T
A
N
T**

Benefit Description	You pay
Inpatient hospital	
Room and board, such as <ul style="list-style-type: none"> • ward, semiprivate, or intensive care accommodations; • general nursing care; and • meals and special diets NOTE: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$100 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood and blood products • Blood or blood plasma, if not donated or replaced • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Take-home items • Medical supplies, appliances, medical equipment, and any covered items billed by a hospital for use at home 	Nothing
Not covered: <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care 	<i>All charges.</i>

Outpatient hospital or ambulatory surgical center	You pay
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>NOTE: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$25 per visit
<p>Outpatient hospital services:</p> <ul style="list-style-type: none"> • Diagnostic laboratory tests, X-rays, and pathology services • Pre-surgical testing 	Nothing
<i>Not covered: blood and blood derivatives not replaced by the member</i>	<i>All charges.</i>
Extended care benefits/skilled nursing care facility benefits	
<p>All necessary services ordered by a Plan doctor are covered, including:</p> <ul style="list-style-type: none"> • Unlimited days • bed, board, and general nursing care • drugs, biologicals, supplies, and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a Plan doctor • Care must be received from a state licensed nursing facility. 	\$100 per admission
<i>Not covered: custodial care</i>	<i>All charges.</i>
Hospice care	
<ul style="list-style-type: none"> • 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 an RN, LPN, LVN or home health aide for patient care for up to 8 hours a day • Social services • Psychological and dietary counseling • Physical or occupational therapy • Consultation and case management services by a participating practitioner • Medical supplies and drugs prescribed by a participating practitioner 	Nothing
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</i>
Ambulance	
<ul style="list-style-type: none"> • Local professional ground and/or air ambulance service when medically necessary and plan approved hospital transfers. 	Nothing

Section 5 (d). Emergency services/accidents

I
M
P
O
R
T
A
N
T

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure.
- We have no calendar year deductible for In Network services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

I
M
P
O
R
T
A
N
T

What is a medical emergency?

A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency:

In the event of an Emergency Medical Condition, go to the closest emergency room, or call 911 for assistance. Sioux Valley Health Plan will cover Emergency Services whether you are in or out of the Service Area. Sioux Valley Health Plan offers world-wide emergency coverage. Prior approval for treatment of Emergency Medical Conditions is not required. You should have someone telephone Sioux Valley Health Plan at 1-800/805-7938 (TTY 605/328-6869) as soon as reasonably possible.

Emergency services are covered inpatient or outpatient services that are furnished by any Provider qualified to furnish such services; and needed to evaluate or stabilize an Emergency Medical Condition.

Emergencies within our service area: If you have an Emergency Medical Condition within the Service Area, you should contact your PCP and the Plan after an emergency so that we can arrange for your follow-up care.

Emergencies outside our service area: If you have an Emergency Medical Condition while out of the Service Area, we prefer that you return to the Service Area to receive care through Plan Participating Providers after you have been treated for your condition. However, services will be covered out of the Service Area as long as the care required continues to meet the definition for either Emergency Services or Urgently Needed Services.

Whether you are inside or outside of the Plan's service area, a \$50 copay for Emergency or Urgent services applies. However, this copay is waived if you are admitted to a hospital within 30 days for the same diagnosis.

Post-Stabilization Care

We also provide coverage for services needed to ensure that you remain stabilized (or, in certain instances, to improve or resolve your condition) if:

- We provide prior approval for such services; or
- The services were not pre-approved by us, but were administered within 1 hour of a request from the Provider for prior approval of additional post-stabilization care; or
- We do not respond within one (1) hour to a request for prior approval from a Non-Contracting Medical Provider or Facility (or Sioux Valley Health Plan could not be contacted for prior approval).

Coverage for Post-Stabilization Care is effective until:

- You are discharged; or
- A Contracting Medical Provider with privileges at the hospital in which you are treated arrives and assumes responsibility for your care; or
- The Non-Contracting Medical Provider and Sioux Valley Health Plan agree to other arrangements; or
- A Contracting Medical Provider assumes responsibility for your care through transfer.

Remember, if you receive services from Non-Contracting Medical Providers without Prior approval, except for Emergency Services, Urgently Needed Services, or out-of-area renal dialysis, Sioux Valley Health Plan will pay for those services at the

Out-of-Network benefit level.**Refunds for Emergency, Urgently Needed, or Out-of-Area Dialysis Services Paid by Members:**

Providers should submit bills to Sioux Valley Health Plan for payment. However, if you paid for any Emergency Services, Urgently Needed Services, or Out-of-Area Renal Dialysis services obtained from Non-Contracting Medical Providers, you should submit your bills to Sioux Valley Health Plan for payment. Bills should be submitted to the following address:

Sioux Valley Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110

If you have questions about any bills, contact the SVHP Member Service Department at 1-800/752-5863 or 605/328-6800. The TTY # is 605/328-6869. (The hours of operation for these numbers are 8:00a.m. until 5:00p.m. Central Standard Time, Monday through Friday.)

Benefit Description	You pay
Emergency within our service area	
<ul style="list-style-type: none">• Emergency care at a doctor's office• Emergency care at an urgent care center• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	\$50 per visit, waived if admitted
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</i>
Emergency outside our service area	
<ul style="list-style-type: none">• Emergency care at a doctor's office• Emergency care at an urgent care center• Emergency care as an outpatient or inpatient at a hospital, including doctors' services	\$50 per visit, waived if admitted
<i>Not covered:</i> <ul style="list-style-type: none">• Elective care or non-emergency care• Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area• Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area	<i>All charges.</i>
Ambulance	
Professional ground ambulance, air ambulance, or regularly scheduled flight on a commercial airline when service is medically necessary. See 5(c) for non-emergency service.	Nothing

Section 5 (e). Mental health and substance abuse benefits

**I
M
P
O
R
T
A
N
T**

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Here are some important things to keep in mind about these benefits:

- All benefits are subject to the definitions, limitations, and exclusions in this brochure.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR APPROVAL OF THESE SERVICES.** See the instructions after the benefits description below.

**I
M
P
O
R
T
A
N
T**

Benefit Description	You Pay
Mental health and substance abuse benefits	
All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. NOTE: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.	Your cost sharing responsibilities are no greater than for other illness or conditions.
<ul style="list-style-type: none"> • Outpatient Professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers. • Medication management. 	\$10 per visit
<ul style="list-style-type: none"> • Diagnostic tests 	Nothing
<ul style="list-style-type: none"> • Services provided by a hospital or other facility 	\$100 per inpatient admission
<i>Not covered: Services we have not approved.</i>	<i>All charges.</i>

Prior approval

To be eligible to receive these benefits you must obtain a treatment plan and follow all the following authorization processes:

All requests for elective inpatient hospitalizations are to be made by the Physicians office at least three (3) days prior to the scheduled admission. Sioux Valley Health Plan's Health Services Department is available between the hours of 8:00a.m. and 5:00p.m. Central Time, Monday through Friday, by calling the Plan's toll-free number 1-800/805-7938.

The Health Services Department will review the Member profile information against standard criteria. A determination will be made by the Health Services Department within two (2) business days of the initial notification. The determination shall either be authorization of the requested service or additional review by the Health Plan Medical Director.

If the determination is to authorize the requested service, the attending practitioner and those Providers involved in the provision of the service shall be notified of the decision by telephone within *one (1)* business day of the initial determination. When the service is approved, the Health Services Department will assign an authorization/certification number. Written notification shall be sent to the attending practitioner, those Providers involved in the provision of the service and the Member within *three (3)* business days of the date of authorization.

When the request requires further review because a denial is being recommended by the Health Services staff, an intensified review will be performed by the Medical Director. If additional documentation is required, the Member, his or her representative, and/or the Provider shall be responsible for submitting any necessary information. A determination either authorizing or denying the request for services will be made within *two (2)* business days after the initial determination or, if additional information is necessary, within *two (2)* business days from the receipt of all necessary documentation. If information is not submitted within thirty (30) days, the Utilization Management (UM) record is closed and services will be denied. The attending practitioner, those Providers involved in the provision of the service and the Member shall be notified of the decision by telephone within *twenty-four (24) hours* of the determination. Those Providers involved in the provision of the service and the Member shall be provided with written notification of the decision within *two (2)* business days of the date of the determination.

If the decision is to deny a hospital or surgical facility admission or other service, it is the plan's policy to notify the attending physician and hospital of the determination by telephone and in writing within one (1) business day of the determination. The Member and those Providers who are involved in the provision of the service shall be informed of the reasons for the denial and the Plan's appeal procedures. In addition, 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.

Limitation We may limit your benefits if you do not obtain a treatment plan.

Section 5 (f). Prescription drug benefits

**I
M
P
O
R
T
A
N
T**

Here are some important things to keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- We have no calendar year deductible for In Network services.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**I
M
P
O
R
T
A
N
T**

There are important features you should be aware of. These include:

- **Who can write your prescription.** A licensed physician, Nurse Practitioner, or Physician’s Assistant must write the prescription.
- **Where you can obtain them.** You may fill the prescription at a pharmacy, a non-network pharmacy, or by mail. We pay a higher level of benefits when you use a network pharmacy.
- **We use a formulary.** However, we have an open formulary. If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call 605/328-6800.
- **These are the dispensing limitations.** Prescriptions can be filled for up to a 30 day supply per copayment. Those prescription drug classes identified as maintenance medications will be made available for up to a 90-day supply. However, three copayments will apply. A generic equivalent will be dispensed if it is available, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. Additionally, if there is no generic equivalent, you will still be required to pay the brand name copayment.
- **Why use generic drugs?** To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.
- **When you have to file a claim.** Please submit all claims directly to us at: Sioux Valley Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. Claim forms are available at your request. You may, however, submit your itemized prescription receipt with date, supply, drug name, and all necessary member information in lieu of a claim form.

Benefit Description	You pay
Covered medications and supplies	
<p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician’s prescription for their purchase, except those listed as <i>Not covered</i>. • Insulin • Glucose test strips • Disposable needles and syringes for the administration of covered medications • Drugs for sexual dysfunction (see Prior approval section on pages 10-12) • Contraceptive drugs and devices 	<p>\$ 10 per generic drug \$ 20 per brand name drug NOTE: If there is no generic equivalent available, you will still have to pay the brand name copay.</p>

Covered medications and supplies (continued)	You Pay
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes including appetite suppressants</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Nonprescription medicines</i> • <i>Orthomolecular therapy</i> • <i>B-12 injections</i> 	<p><i>All charges.</i></p>

Section 5 (g). Special Features

Feature	Description
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call Healthformation at 605/333-4444 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	For individuals needing assistance, please contact the Plan TTY line at 605/328-6869.
High risk pregnancies	Individuals may contact the Healthy Pregnancy Program at 1-800/752-5863 to enroll.
Centers of excellence for transplants	The Plan utilizes the LifeTrac Centers of Excellent Network for transplant services. Please contact the Plan at 605/328-6807 for any information needed.

Section 5 (h). Dental benefits

**I
M
P
O
R
T
A
N
T**

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan dentists must provide or arrange your care.
- We have no calendar year deductible for in network coverage.
- We cover hospitalization for dental procedures only when a nondental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient; we do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**I
M
P
O
R
T
A
N
T**

Accidental injury benefit	You pay
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth. The need for these services must result from an accidental injury.	\$10 per visit \$25 per outpatient surgery \$100 per inpatient stay
Dental Benefits	You pay
<ul style="list-style-type: none"> • Dental service required for cancer that damages sound natural teeth. • Associated radiology services • TMJ Dental Services <p>We have no other dental benefits</p>	\$10 per visit \$25 per outpatient surgery \$100 per inpatient stay

Section 5 (i). Point of service benefits

**I
M
P
O
R
T
A
N
T**

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- The calendar year deductible is: \$500 per person and \$1,000 per family.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

**I
M
P
O
R
T
A
N
T**

Point of Service (POS) Benefits

Facts about this Plan's POS option

You may choose to obtain benefits covered by this Plan's POS options from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Benefits not covered under POS must either be received from or arranged by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without authorization from the Plan, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered

- Medical Office Visits
- Preventive Health Services including Well Baby and Well Child Care (up to 6 years old), routine periodic preventive health exams, immunizations, allergy testing and treatment, and allergy serum
- Emergency Services
- X-Ray and Laboratory Services
- Acute Inpatient Hospital Services
- Maternity, Pregnancy and Newborn Care
- Inpatient Physician Services and Consultations
- Outpatient Hospital Services
- Outpatient Surgery
- Home Health Care
- Skilled Nursing Facility Service
- Mental Health Services
- Inpatient Chemical Dependency Services
- Inpatient Alcohol Treatment
- Durable Medical Equipment and Prosthetic Devices (prior approval required for rentals or purchases over \$200).
- Orthopedic Appliances
- Outpatient Rehabilitative Therapy
- Oral Surgery and Other Dental Services

What is Not Covered

- Tobacco Treatment;
- Chiropractic Services;
- Transplants at Non-Participating Center of Excellence Facilities;
- Custodial care; and
- All other services not listed in the “What is covered” Section above.

You pay 40% of the allowed benefit after paying the deductible and any charges greater than the allowed benefit.

All participating providers are paid at the In-Network Benefit level and only the out-of-network doctor and/or facility charges are paid at the Out-of-Network POS level. Services obtained within or outside of the service area by non-Plan Participating Providers are eligible for coverage under POS.

Outpatient substance abuse benefits

You pay 70% of our allowed benefit and any charges above the allowed \$30 benefit, after the deductible for all covered chemical dependency and alcohol treatment services.

Transplant services at designated transplant facilities

You pay a nominal charge per course of treatment.

Ambulance and other transportation services

You pay 20% of our allowed benefit and any charges above the allowed benefit, after the deductible, for all covered services. Prior approval is only required for non-emergency transportation.

Deductible

The deductible is the amount that a Member must pay at the time services are received before the Plan will pay for such services. The deductible for Point of Service benefits is \$500 for the individual and \$1,000 for the family.

Coinsurance

Coinsurance is the percentage of charges to be paid by a Member for services at the time such services are rendered. The Plan's coinsurance for Point of Service benefits is 60%; you pay 40%, except for ambulance and other transportation services and outpatient substance abuse services which have a different coinsurance. The fee schedule is set at the 90th percentile of the standard Usual and Customary Rate (UCR) allowance for our region. You will be liable for your coinsurance percentage plus any charges in excess of the UCR allowance.

Maximum benefit

There is no lifetime maximum benefit under the POS plan.

Out-of-pocket maximum

The catastrophic limit on Member's out-of-pocket Point of Service expenses per calendar year is \$10,000 for the individual and \$10,000 for the family (this does not apply to transplant services). Member's out-of-pocket expenses under POS qualify for the Plan's out-of-pocket maximum.

Hospital/extended care

The Plan will pay a participating hospital in full even though the POS benefit (and non-Plan doctor) are being used. The hospital charge, sometimes called facility charge, does not cover any charges for doctors' services.

Emergency benefits

True emergency care is always payable as an in-Plan benefit; there is a \$50 copay but the copay is waived if admitted to a hospital.

Outpatient substance abuse benefits

For chemical dependency services, the POS benefit pays 30% of eligible reasonable and customary charges up to a \$30 limit; you pay 70%. Also, for alcohol treatment, the POS benefit pays 30% of eligible reasonable and customary charges up to a \$30 limit; you pay 70%.

How to obtain benefits

To access POS benefits you may see the physician or obtain services at the facility of your choice. Benefits will be paid at 60% after the Out-of-Network deductible is met; you pay 40%, except for ambulance and other transportation services and outpatient substance abuse services which have a different coinsurance. The Plan will need a claim from the member, including a CPT code, date of service, diagnosis code, name of doctor or hospital, member's birthdate and identification number. Submit your claims to:

Sioux Valley Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition and we agree, as discussed under *What Services Require Our Prior Approval* on page 10.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies that are not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations; and
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical, hospital and drug benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Facilities will file on the UB-92 form. For claims questions and assistance, call Member Services at 605/328-6800 or toll free at 1-800/752-5863 (TTY 605/328-6869).

When you must file a claim -- such as for out-of-area care -- submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer --such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to:

Sioux Valley Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for prior approval:

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <p>(a) Write to us within 6 months from the date of our decision; and Send your request to us at: Sioux Valley Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110;</p> <p>(b) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and</p> <p>(c) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.</p>
2	<p>We have 30 days from the date we receive your request to:</p> <p>(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or</p> <p>(b) Write to you and maintain our denial -- go to step 4; or</p> <p>(c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.</p>
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within:</p> <ul style="list-style-type: none">• 90 days after the date of our letter upholding our initial decision; or• 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or• 120 days after we asked for additional information. <p>Write to OPM at: Office of Personnel Management, Office of Insurance Programs, Contracts Division 3, 1900 E Street, NW, Washington, DC 20415-3630.</p>

The Disputed Claims process (*Continued*)

Send OPM the following information:

- A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure;
- Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms;
- Copies of all letters you sent to us about the claim;
- Copies of all letters we sent to you about the claim; and
- Your daytime phone number and the best time to call.

Note: If you want OPM to review different claims, you must clearly identify which documents apply to which claim.

Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.

Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.

- 5** OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.
- 6** If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.

You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

NOTE: If you have a serious or life threatening condition (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- (a) We haven't responded yet to your initial request for care or prior approval/prior approval, then call us at 605/328-6807 and we will expedite our review; or
- (b) We denied your initial request for care or prior approval/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You can call OPM's Health Benefits Contracts Division 3 at 202/606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage You must tell us if you are covered or a family member is covered under another group health plan or have automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance.

•What is Medicare?

Medicare is a Health Insurance Program for:

- People 65 years of age and older.
- Some people with disabilities, under 65 years of age.
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has two parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (Someone who was a Federal employee on January 1, 1983 or since automatically qualifies.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800/MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare + Choice is the term used to describe the various health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on the type of Medicare managed care plan you have.

•The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share. Some things are not covered under Original Medicare, like prescription drugs.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

We will not waive any of our copayments, coinsurance, and deductibles.

The following chart illustrates whether the Original Medicare Plan or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly.

Primary Payer Chart		
A. When either you -- or your covered spouse -- are age 65 or over and ...	Then the primary payer is...	
	Original Medicare	This Plan
1) Are an active employee with the Federal government (including when you or a family member are eligible for Medicare solely because of a disability),		✓
2) Are an annuitant,	✓	
3) Are a reemployed annuitant with the Federal government when... a) The position is excluded from FEHB, or	✓	
b) The position is not excluded from FEHB (Ask your employing office which of these applies to you)		✓
4) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge),	✓	
5) Are enrolled in Part B only, regardless of your employment status,	✓ (for Part B services)	✓ (for other services)
6) Are a former Federal employee receiving Workers' Compensation and the Office of Workers' Compensation Programs has determined that you are unable to return to duty,	✓ (except for claims related to Workers' Compensation.)	
B. When you -- or a covered family member -- have Medicare based on end stage renal disease (ESRD) and...		
1) Are within the first 30 months of eligibility to receive Part A benefits solely because of ESRD,		✓
2) Have completed the 30-month ESRD coordination period and are still eligible for Medicare due to ESRD,	✓	
3) Become eligible for Medicare due to ESRD after Medicare became primary for you under another provision,	✓	
C. When you or a covered family member have FEHB and...		
1) Are eligible for Medicare based on disability, and a) Are an annuitant, or	✓	
b) Are an active employee, or		✓
c) Are a former spouse of an annuitant, or	✓	
d) Are a former spouse of an active employee		✓

Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan -- You probably will never have to file a claim form when you have both our Plan and the Original Medicare Plan.

- When we are the primary payer, we process the claim first.
- When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claims will be coordinated automatically and we will pay the balance of covered charges. You will not need to do anything. To find out if you need to do something about filing your claims, call us at 605/328-6800 or 1-800/752-5863.

We do not waive any costs when you have Medicare.

• Medicare managed care plan

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from another type of Medicare+Choice plan -- a Medicare managed care plan. These are health care choices (like HMOs) in some areas of the country. In most Medicare managed care plans, you can only go to doctors, specialists, or hospitals that are part of the plan. Medicare managed care plans provide all the benefits that Original Medicare covers. Some cover extras, like prescription drugs. To learn more about enrolling in a Medicare managed care plan, contact Medicare at 1-800/MEDICARE (1-800/633-4227) or at www.medicare.gov.

If you enroll in a Medicare managed care plan, the following options are available to you:

This Plan and our Medicare managed care plan: You may enroll in our Medicare managed care plan and also remain enrolled in our FEHB plan. In this case, we do not waive any of our copayments, coinsurance, or deductibles for your FEHB coverage.

This Plan and another plan's Medicare managed care plan: You may enroll in another plan's Medicare managed care plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare managed care plan is primary, even out of the managed care plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare managed care plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare managed care plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare managed care plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare managed care plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare managed care plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next open season unless you involuntarily lose coverage or move out of the Medicare managed care plan's service area.

• If you do not enroll in Medicare Part A or Part B

If you do not have one or both Parts of Medicare, you can still be covered under the FEHB Program. We will not require you to enroll in Medicare Part B and, if you can't get premium-free Part A, we will not ask you to enroll in it.

TRICARE

TRICARE is the health care program for eligible dependents of military persons and retirees of the military. TRICARE includes the CHAMPUS program. If

both TRICARE and this Plan cover you, we pay first. See your TRICARE Health Benefits Advisor if you have questions about TRICARE coverage.

Workers' Compensation

We do not cover services that:

- you need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care. You must use our provider.

Medicaid

When you have this Plan and Medicaid, we pay first.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal Government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement. If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

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 subrogation provisions discussed above.

Member's Responsibilities

The Member 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 provision. The Member shall take no action prejudicing the rights and interests of the Plan under this provision. Any Member who fails to cooperate in the Plan's administration of this subrogation provision 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.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through December 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on December 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. See page 13, <i>Section 4</i> .
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See page 13, <i>Section 4</i> .
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care in which room, board, and other personal assistance services are provided, generally on a long-term basis and which does not include a medical component.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See page 13, <i>Section 4</i> .
Experimental or investigational services	Any healthcare services where the Healthcare service in question is either: 1) not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or 2) requires approval by any governmental authority and such approval has not been granted prior to the service being rendered.
Medical necessity	Health care services that are appropriate, in terms of type, frequency, level, setting, and duration, to the Members diagnosis or condition, and diagnostic testing and preventative services. Medically necessary care must: <ul style="list-style-type: none">• Be consistent with generally accepted standards of medical practice as recognized by the plan, as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and• Help restore or maintain the Member's health; or• Prevent deterioration of the Member's condition; or• Prevent the reasonably likely onset of a health problem or detect an incipient problem; or• Not considered experimental or investigative.
Plan allowance	Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows: For in-network coverage the allowance is based on a percent of discounted charges that the Plan has negotiated with Participating Providers; in-network providers accept the plan allowance as payment in full. For out-of-network providers the allowance is based on a percent of eligible reasonable and customary charges.
Us/We	Us and we refer to <i>Sioux Valley Health Plan</i>

Utilization Management

A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or facilities.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB facts

No pre-existing condition limitation

We will not refuse to cover the treatment of a condition that you had before you enrolled in this Plan solely because you had the condition before you enrolled.

Where you can get information about enrolling in the FEHBP Program

See www.opm.gov/insure. Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Employees Health Benefits Plans*, brochures for other plans, and other materials you need to make an informed decision about:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- When your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive health benefits, nor will we. Please tell us immediately when you add or remove family members from your coverage for any reason, including divorce, or when your child under age 22 marries or turns 22.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

When benefits and premiums start

The benefits in this brochure are effective on January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

Your medical and claims records are confidential

We will keep your medical and claims information confidential. Only the following will have access to it:

- OPM, this Plan, and subcontractors when they administer this contract;
- This Plan and appropriate third parties, such as other insurance plans and the Office of Workers' Compensation Programs (OWCP), when coordinating benefit payments and subrogating claims;
- Law enforcement officials when investigating and/or prosecuting alleged civil or criminal actions;
- OPM and the General Accounting Office when conducting audits;
- Individuals involved in bona fide medical research or education that does not disclose your identity; or
- OPM, when reviewing a disputed claim or defending litigation about a claim.
- **records are confidential**

When you retire

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as temporary continuation of coverage (TCC).

When you lose benefits

• When FEHB coverage ends

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage.

• Spouse equity coverage

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. But, you may be eligible for your own FEHB coverage under the spouse equity law. If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices.

• Temporary continuation of coverage (TCC)

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Employees Health Benefits Plans for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing

or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

●Converting to individual coverage

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert)
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

Getting a Certificate of Group Health Plan Coverage

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information get OPM pamphlet RI 79-27, Temporary Continuation of Coverage (TCC) under the FEHB Program. See also the FEHB web site (www.opm.gov/insure/health); refer to the "TCC and HIPAA" frequently asked question. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and it has information about Federal and State agencies you can contact for more information.

Long Term Care Insurance Is Coming Later in 2002!

- Many FEHB enrollees think that their health plan and/or Medicare will cover their long-term care needs. Unfortunately, they are *WRONG!*
- How are YOU planning to pay for the future custodial or chronic care you may need?
- You should consider buying long-term care insurance.

The Office of Personnel Management (OPM) will sponsor a high-quality long term care insurance program effective in October 2002. As part of its educational effort, OPM asks you to consider these questions:

What is long term care (LTC) insurance?

- It's insurance to help pay for long term care services you may need if you can't take care of yourself because of an extended illness or injury, or an age-related disease such as Alzheimer's.
- LTC insurance can provide broad, flexible benefits for nursing home care, care in an assisted living facility, care in your home, adult day care, hospice care, and more. LTC insurance can supplement care provided by family members, reducing the burden you place on them

I'm healthy. I won't need long term care. Or, will I?

- Welcome to the club!
- 76% of Americans believe they will never need long term care, but the facts are that about half of them will. And it's not just the old folks. About 40% of people needing long term care are under age 65. They may need chronic care due to a serious accident, a stroke, or developing multiple sclerosis, etc.
- We hope you will never need long term care, but everyone should have a plan just in case. Many people now consider long term care insurance to be vital to their financial and retirement planning.

Is long term care expensive?

- Yes, it can be very expensive. A year in a nursing home can exceed \$50,000. Home care for only three 8- hour shifts a week can exceed \$20,000 a year. And that's before inflation!
- Long term care can easily exhaust your savings. *Long term care insurance can protect your savings.*

But won't my FEHB plan, Medicare or Medicaid cover my long term care?

- Not FEHB. Look at the "Not covered" blocks in sections 5(a) and 5(c) of your FEHB brochure. Health plans don't cover custodial care or a stay in an assisted living facility or a continuing need for a home health aide to help you get in and out of bed and with other activities of daily living. Limited stays in skilled nursing facilities can be covered in some circumstances.
- Medicare only covers skilled nursing home care (the highest level of nursing care) after a hospitalization for those who are blind, age 65 or older or fully disabled. It also has a 100 day limit.
- Medicaid covers long term care for those who meet their state's poverty guidelines, but has restrictions on covered services and where they can be received. *Long term care insurance can provide choices of care and preserve your independence.*

When will I get more information on how to apply for this new insurance coverage?

- Employees will get more information from their agencies during the LTC open enrollment period in the late summer/early fall of 2002.
- Retirees will receive information at home.

How can I find out more about the program NOW?

- Our toll-free teleservice center will begin in mid-2002. In the meantime, you can learn more about the program on our web site at www.opm.gov/insure/ltc.

Index

Do not rely on this page; it is for your convenience and may not show all pages where the terms appear.

- Accidental injury 28
Allergy tests 18
Alternative treatment 22
Allogeneic (donor) bone marrow transplant 25
Ambulance 27, 29
Anesthesia 25-27
Autologous bone marrow transplant 25
Biospies 23
Birthing centers 17
Blood and blood plasma 26
Breast cancer screening 16
Casts 21
Catastrophic protection 13
Chemotherapy 18
Childbirth 17
Chiropractic 22
Cholesterol tests 16
Claims 40-42
Coinsurance 13,47
Colorectal cancer screening 16
Congenital anomalies 23-24
Contraceptive devices and drugs 17, 32
Coordination of benefits 43
Covered charges 9, 14-38
Covered providers 9, 14-38
Crutches 21
Deductible 13, 47
Definitions 47
Dental care 35
Diagnostic services 15
Disputed claims review 41
Donor expenses (transplants) 25
Dressings 26
Durable medical equipment (DME) 21
Educational classes and programs 22
Effective date of enrollment 49
Emergency 28
Experimental or investigational 39
Eyeglasses 19
Family planning 17
Fecal occult blood test 16
General Exclusions 39
Hearing services 19
Home health services 21-22
Hospice care 27
Home nursing care 21-22
Hospital 26-27
Immunizations 16
Infertility 18
Inhospital physician care 26-27
Inpatient Hospital Benefits 26-27
Insulin 32
Laboratory and pathological services 26
Magnetic Resonance Imagings (MRIs) 15
Mail Order Prescription Drugs 32
Mammograms 16
Maternity Benefits 17
Medicaid 46
Medically necessary 47
Medicare 43-45
Mental Conditions/Substance Abuse Benefits 30-31
Newborn care 17
Nursing Care 26-27
 Nurse Anesthetist 26
 Nurse Practitioner 32
Obstetrical care 17
Occupational therapy 19
Ocular injury 19
Office visits 15
Oral and maxillofacial surgery 24
Orthopedic devices 20
Out-of-pocket expenses 13
Outpatient facility care 27
Pap test 16
Physical examination 16
Physical therapy 19
Physician 32
Physician's Assistant 32
Point of service (POS) 36-38
Prior approval 10-12, 30-31, 37
Preventive care, adult 16
Preventive care, children 16
Prescription drugs 32-33
Preventive services 16
Prostate cancer screening 16
Prosthetic devices 20
Psychologist 30
Radiation therapy 18
Renal dialysis 18
Room and board 26-27
Second surgical opinion 15
Skilled nursing facility care 27
Smoking cessation 22
Speech therapy 19
Sterilization procedures 17, 23
Subrogation 46
Substance abuse 30-31
Surgery 23
 • Anesthesia 25-27
 • Oral 24
 • Outpatient 27
 • Reconstructive 24
Temporary continuation of coverage 50
Transplants 25, 34
Treatment Therapies 18
Vision services 19
Well child care 16
Wheelchairs 21
Workers' compensation 46
X-rays 15

Summary of benefits for the *Sioux Valley Health Plan 2002*

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: • Diagnostic and treatment services provided in the office	Office visit copay: \$10 per primary care visit; \$10 per specialist visit	15
Services provided by a hospital: • Inpatient • Outpatient Surgery • Outpatient Hospital Services • Outpatient Rehabilitative Services (cardiac rehab, physical, occupational, and speech therapies)	\$100 per admission \$25 per visit Nothing \$10 per outpatient visit	26 27 27 19
Emergency benefits: • In-area • Out-of-area	\$50; waived if admitted \$50; waived if admitted	29 29
Mental health and substance abuse treatment	\$100 per admission \$10 per outpatient visit	30
Prescription drugs	\$ 10 per 30 day supply for generic medications \$ 20 per 30 day supply for brand name medications NOTE: If there is no generic equivalent available, you will still have to pay the brand name copay.	32
Dental Care	Benefits only for accidental injury, cancer that damages teeth and TMJ services. \$10 per visit \$25 per outpatient visit \$100 per inpatient stay	35
Vision Care	Eye exams for children up to age 17. Eyeglasses or one pair of contact lenses to correct an impairment directly caused by injury.	19

Special features: 24 hour nurse line, Services for deaf and hearing impaired, High risk pregnancies, Centers of Excellence for transplants		34
Point of Service benefits -- Yes		36-38
Protection against catastrophic costs (your out-of-pocket maximum).....	Nothing after \$1,500/Self Only or \$3,000/Family enrollment per year Any costs above reasonable and customary charges do not count toward this protection.	13

2002 Rate Information for Sioux Valley Health Plan

Non-Postal rates apply to most non-Postal enrollees. If you are in a special enrollment category, refer to the FEHB Guide for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the FEHB Guide for United States Postal Service Employees, RI 70-2. Different postal rates apply and special FEHB guides are published for Postal Service Nurses and Tool & Die employees (see RI 70-2B); and for Postal Service Inspectors and Office of Inspector General (OIG) employees (see RI 70-2IN).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization. Refer to the applicable FEHB Guide .

Type of Enrollment	Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Central, Eastern South Dakota and counties surrounding the Rapid City area

Self Only	AU1	\$97.86	\$56.16	\$212.03	\$121.69	\$115.52	\$38.50
Self and Family	AU2	\$223.41	\$106.21	\$484.06	\$230.12	\$263.75	\$65.87