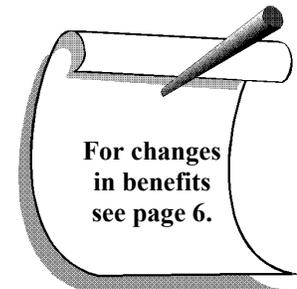


**A Health Maintenance Organization
with a point of service product**

**Serving: Central, Eastern South Dakota and counties surrounding the
Rapid City area, and Northwestern Iowa**

**Enrollment in this Plan is limited. You must live in our
Geographic service area to enroll. See page 4 for requirements.**



Sioux Valley Health Plan and Sioux Valley Health Plan of Minnesota
Commercial HMO products received NCQA Commendable MCO Accreditation
on July 15, 2003 effective through July 15, 2004.



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 High Option Self Only
AU2 High Option Self and Family**

**AU4 Standard Option Self Only
AU 5 Standard Option Self and Family**

Special notice: Members currently enrolled in enrollment codes AU1 Self Only or AU2 Self and Family
will remain in those codes unless the member makes an Open Season change.

Authorized for distribution by the:



UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
RETIREMENT AND INSURANCE SERVICE
[HTTP://WWW.OPM.GOV/INSURE](http://www.opm.gov/insure)





OFFICE OF THE DIRECTOR

UNITED STATES
OFFICE OF PERSONNEL MANAGEMENT
WASHINGTON, DC 20415-0001

Dear Federal Employees Health Benefits Program Participant:

I am pleased to present this 2004 Federal Employees Health Benefits (FEHB) Program plan brochure. The brochure describes the benefits this plan offers you for 2004. Because benefits vary from year to year, you should review your plan's brochure every Open Season – especially Section 2, which explains how the plan changed.

It takes a lot of information to help a consumer make wise healthcare decisions. The information in this brochure, our FEHB Guide, and our web-based resources, make it easier than ever to get information about plans, to compare benefits and to read customer service satisfaction ratings for the national and local plans that may be of interest. Just click on www.opm.gov/insure!

The FEHB Program continues to be an enviable national model that offers exceptional choice, and uses private-sector competition to keep costs reasonable, ensure high-quality care, and spur innovation. The Program, which began in 1960, is sound and has stood the test of time. It enjoys one of the highest levels of customer satisfaction of any healthcare program in the country.

I continue to take aggressive steps to keep the FEHB Program on the cutting edge of employer-sponsored health benefits. We demand cost-effective quality care from our FEHB carriers and we have encouraged Federal agencies and departments to pay the full FEHB health benefit premium for their employees called to active duty in the Reserve and National Guard so they can continue FEHB coverage for themselves and their families. Our carriers have also responded to my request to help our members to be prepared by making additional supplies of medications available for emergencies as well as call-up situations and you can help by getting an Emergency Preparedness Guide at www.opm.gov. OPM's *HealthierFeds* campaign is another way the carriers are working with us to ensure Federal employees and retirees are informed on healthy living and best-treatment strategies. You can help to contain healthcare costs and keep premiums down by living a healthy life style.

Open Season is your opportunity to review your choices and to become an educated consumer to meet your healthcare needs. Use this brochure, the FEHB Guide, and the web resources to make your choice an informed one. Finally, if you know someone interested in Federal employment, refer them to www.usajobs.opm.gov.

Sincerely,

A handwritten signature in black ink, appearing to read "Kay Coles James".

Kay Coles James
Director



Federal Employees
Health Benefits Program

Notice of the Office of Personnel Management's

Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

By law, the Office of Personnel Management (OPM), which administers the Federal Employees Health Benefits (FEHB) Program, is required to protect the privacy of your personal medical information. OPM is also required to give you this notice to tell you how OPM may use and give out ("disclose") your personal medical information held by OPM.

OPM **will** use and give out your personal medical information:

- To you or someone who has the legal right to act for you (your personal representative),
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected,
- To law enforcement officials when investigating and/or prosecuting alleged or civil or criminal actions, and
- Where required by law.

OPM **has the right** to use and give out your personal medical information to administer the FEHB Program. For example:

- To communicate with your FEHB health plan when you or someone you have authorized to act on your behalf asks for our assistance regarding a benefit or customer service issue.
- To review, make a decision, or litigate your disputed claim.
- For OPM and the General Accounting Office when conducting audits.

OPM **may** use or give out your personal medical information for the following purposes under limited circumstances:

- For Government healthcare oversight activities (such as fraud and abuse investigations),
- For research studies that meet all privacy law requirements (such as for medical research or education), and
- To avoid a serious and imminent threat to health or safety.

By law, OPM must have your written permission (an "authorization") to use or give out your personal medical information for any purpose that is not set out in this notice. You may take back ("revoke") your written permission at any time, except if OPM has already acted based on your permission.

By law, you **have the right** to:

- See and get a copy of your personal medical information held by OPM.
- Amend any of your personal medical information created by OPM if you believe that it is wrong or if information is missing, and OPM agrees. If OPM disagrees, you may have a statement of your disagreement added to your personal medical information.

- Get a listing of those getting your personal medical information from OPM in the past 6 years. The listing will not cover your personal medical information that was given to you or your personal representative, any information that you authorized OPM to release, or that was given out for law enforcement purposes or to pay for your health care or a disputed claim.
- Ask OPM to communicate with you in a different manner or at a different place (for example, by sending materials to a P.O. Box instead of your home address).
- Ask OPM to limit how your personal medical information is used or given out. However, OPM may not be able to agree to your request if the information is used to conduct operations in the manner described above.
- Get a separate paper copy of this notice.

For more information on exercising your rights set out in this notice, look at www.opm.gov/insure on the web. You may also call 202-606-0191 and ask for OPM's FEHB Program privacy official for this purpose.

If you believe OPM has violated your privacy rights set out in this notice, you may file a complaint with OPM at the following address:

Privacy Complaints
Office of Personnel Management
P.O. Box 707
Washington, DC 20004-0707

Filing a complaint will not affect your benefits under the FEHB Program. You also may file a complaint with the Secretary of the Department of Health and Human Services.

By law, OPM is required to follow the terms in this privacy notice. OPM has the right to change the way your personal medical information is used and given out. If OPM makes any changes, you will get a new notice by mail within 60 days of the change.

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Introduction

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 Plan is underwritten by Sioux Valley Health Plan. The address for Sioux Valley Health Plan's administrative offices is:

Sioux Valley Health Plan
1100 E. 21st St., Suite 600
Sioux Falls, SD 57105

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in 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, 2004, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2004, and changes are summarized on page 6. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language 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.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits (FEHB) Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud - Here are some things you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider 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 605/328328-6868 and explain the situation.
 - If we do not resolve the issue:

CALL -- THE HEALTH CARE FRAUD HOTLINE
202-418-3300

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

- Do not maintain as a family member on your policy:
 - your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed or with OPM if you are retired.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

- **Ask questions if you have doubts or concerns.**
 - Ask questions and make sure you understand the answers.
 - Choose a doctor with whom you feel comfortable talking.
 - Take a relative or friend with you to help you ask questions and understand answers.
- **Keep and bring a list of all the medicines you take.**
 - Give your doctor and pharmacist a list of all the medicines that you take, including non-prescription medicines.
 - Tell them about any drug allergies you have.
 - Ask about side effects and what to avoid while taking the medicine.
 - Read the label when you get your medicine, including all warnings.
 - Make sure your medicine is what the doctor ordered and know how to use it.
 - Ask the pharmacist about your medicine if it looks different than you expected.
- **Get the results of any test or procedure.**
 - Ask when and how you will get the results of test or procedures.

- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.
- **Talk to your doctor about which hospital is best for your health needs.**
 - Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
 - Be sure you understand the instructions you get about follow-up care when you leave the hospital.
- **Make sure you understand what will happen if you need surgery.**
 - Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
 - Ask your doctor, "Who will manage my care when I am in the hospital?"
 - Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery?
 - How can I expect to feel during recovery?
 - Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/consumer/pathqpack.htm. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality healthcare providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer healthcare for you and your family.
- www.talkaboutrx.org/consumer.html. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and healthcare professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's healthcare delivery system.

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. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

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.

In South Dakota 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.

In Iowa our service area is: Clay, Dickinson, Emmet, Lyon, O'Brien, Osceola, and Sioux.

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. How we changed for 2004

Do not rely on these change descriptions; this page is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- We added information regarding two new Federal Programs that complement FEHB benefits, the Federal Flexible Spending Account Program - *FSAFEDS* and the Federal Long Term Care Insurance Program. See page 50.
- We added information regarding Preventing medical mistakes. See page 2.
- We added information regarding enrolling in Medicare. See page 39.
- We revised the Medicare Primary Payer Chart. See page 41.

Changes to this Plan

- We are offering a new Standard Option Plan, AU4 and AU5 (High Option is now AU1 and AU2).
- Your share of the non-Postal premium for High Option will increase by 59.6% for Self Only or 61% for Self and Family.
- Your specialist office visit copayment increases from \$20 copay to \$30 copay per visit. (Section 5(a))
- Your inpatient hospital copayment increases from \$100 copay per admission to \$100 copay per day up to \$500 per admission. (Section 5 (c)).
- Your ambulance services copayment is \$50. The copayment is waived if you are admitted. (Section 5 (c)).
- Your prescription drugs copayment increase from:
\$10 to \$15 for Generic Drugs
\$20 to \$30 for formulary Brand Name Drugs
\$35 to \$50 for *non-formulary* Brand Name Drugs
(See Section 5(f)).
- Your copayment for diabetic supplies increased from \$10 to \$15 (See Section 5(f)).
- Your home health service copayment is \$20 per visit. (Section 5(a)).
- Your Out of Pocket Maximum will increase from \$1,500 to \$4,000 for Self Only and from \$3,000 to \$4,000 for Self and Family. (Section 4).
- Your maternity care benefit includes 2 routine sonograms per pregnancy to determine fetal age, size or sex. (Section 5(a)).

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 or write to us at PO Box 91110 Sioux Falls, SD 57109-1110. You may also request replacement cards through our website at www.siouxvalley.org.

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 you. 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 you. 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 our 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. Appropriate access for Primary Care Physicians and Hospital Provider sites is within thirty (30) miles of your city of residence. Appropriate access includes access to our providers when you have traveled outside of the service area. If you are traveling within the service area where other Plan providers are available then you must use Plan providers.

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. Appropriate access for Specialty Physicians and Hospital Provider sites is within ninety (90) miles of your city of residence. Appropriate access includes access to Plan providers when you have traveled outside of the service area. If you are traveling within the service area where other Plan providers are available then you must use Plan providers.

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

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

We determine approval for prior authorization based on appropriateness of care and service and existence of coverage.

Services that Require Prior Authorization Include:

- Inpatient hospital admissions including admissions for medical, surgical, neonatal intensive care nursery, mental health and chemical dependency services;
- Partial Hospital Program (PHP)/Day Treatment for mental health and chemical dependency services;
- Selected Outpatient Surgeries;
- Physician office site surgical center;
- Home Health, Hospice and Home IV therapy services;
- Durable Medical Equipment (rental or purchase over \$200);
- Rehabilitative services; including speech, occupational and physical therapy and one to one water therapy;
- Skilled nursing and sub-acute care;
- Organ transplants;
- Ambulance Services for non-emergency situations; and
- Referrals to Non-Participating Providers which are recommended by Participating Providers. Prior authorization is required for the purposes of receiving In-Network coverage only. If prior authorization is not obtained for referrals to Non-Participating Providers, the services will be covered at the Out of Network coverage level. Prior authorization does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in Part III, Section A.

Prior approval Process

To receive detailed instructions on the prior authorization process for elective inpatient hospitalizations, non urgent care, pharmaceutical decisions, behavioral health, urgent/emergency conditions, concurrent review and retrospective review (post-service) contact our Health Services Department, available between the hours of 8:00a.m. and 5:00p.m. Central Standard Time, Monday through Friday, by calling our toll-free number 1-800-805-7938 or (650)328-6807. After hours you may leave a message on the confidential voice mail of the Health Services Department and someone will return your call. You are ultimately responsible for obtaining prior authorization from the Health Services Department. Failure to obtain prior authorization will result in a reduction to the Out of Network benefits level. However, information provided by the physician's office also satisfies this requirement.

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: Under High Option, your office visit copayment per visit is \$20 for primary care physicians and \$30 for Specialist. Under Standard Option, office visit copayments are \$25 per visit.

- **Deductible**

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them.

Example: Under High Option, deductibles only apply when you use our Point of Services (POS) benefits. There is a \$500 deductible for Self enrollment and a \$1,000 deductible for Self and Family enrollment. Under Standard Option, deductibles apply to both Participating providers and POS benefits. The deductible for Participating provider benefits is \$500 Self enrollment and \$1,000 Self and Family. The POS benefit deductible is \$1,000 Self enrollment and \$3,000 Self and Family.

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 (there is no deductible for in-network care under the High Option).

Example: Under **High Option**, 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. Under **Standard Option**, you pay 20% of our allowance for office visits when you receive services from Participating Providers or you pay 40% of our allowance for medical office visits when you receive services from non-Participating Providers with POS benefits.

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

Under the **High Option**, after your in-network copayments total \$4,000 Self enrollment or \$4,000 Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. Under the **Standard Option**, after your in-network copayments and coinsurances total \$3,000 Self enrollment or \$4,000 Self and 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 catastrophic protection 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 6 for how our benefits changed this year and pages 55-56 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 claim 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	16
	<ul style="list-style-type: none"> • Diagnostic and treatment services • Lab, X-ray, and other diagnostic tests • Preventive care, adult • Preventive care, children • Maternity care • Family planning • Infertility services • Allergy care • Treatment therapies • Physical, cardiac and occupational therapies 	<ul style="list-style-type: none"> • Speech therapy • Hearing services (testing, treatment, and supplies) • Vision services (testing, treatment, and supplies) • Foot care • Orthopedic and prosthetic devices • Durable medical equipment (DME) • Home health services • Chiropractic • Alternative treatments • Educational classes and programs
(a)	Surgical and anesthesia services provided by physicians and other health care professionals.....	20
	<ul style="list-style-type: none"> • Surgical procedures • Reconstructive surgery 	<ul style="list-style-type: none"> • Oral and maxillofacial surgery • Organ/tissue transplants • Anesthesia
(a)	Services provided by a hospital or other facility, and ambulance services	23
	<ul style="list-style-type: none"> • Inpatient hospital • Outpatient hospital or ambulatory surgical center 	<ul style="list-style-type: none"> • Extended care benefits/skilled nursing care facility benefits • Hospice care • Ambulance
(a)	Emergency services/accidents	25
	<ul style="list-style-type: none"> • Medical emergency 	<ul style="list-style-type: none"> • Ambulance
(b)	Mental health and substance abuse benefits	27
(c)	Prescription drug benefits.....	28
(d)	Special features	30
	<ul style="list-style-type: none"> • 24 Hour Nurse Line • Services for deaf and hearing impaired • Pregnancy Program • Centers of Excellence for transplants 	
(h)	Dental benefits	31
(i)	Point of service benefits	32
	Summary of benefits.....	55-56

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

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

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- 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.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for In Network services is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive In Network benefit coverage.
- 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.

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Benefit Description	You pay - High Option	You pay - Standard Option
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 	\$20 copay per primary care visit \$30 copay per specialist visit	\$25 copay primary or specialist per visit (No deductible)
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility 	Nothing	Nothing
Home visits	Nothing	Nothing
Lab, X-ray and other diagnostic 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	20% of charges

Preventive care, adult	You pay - High Option	You pay - Standard Option
Routine screenings, such as: <ul style="list-style-type: none"> Total Blood Cholesterol – lipid profile between ages 18-24, once every five years between ages 25-44 and once every year ages 45 and over Colorectal Cancer Screening, including: <ul style="list-style-type: none"> Fecal occult blood test Sigmoidoscopy, screening – every five years starting at age 50 Colonoscopy – once every 10 years at age 50, or Double contrast barium enema (DCBE) – once every 5 to 10 years starting at age 50 Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older 	Nothing	\$25 copay per visit (No deductible)
Routine pap test NOTE: The office visit is covered if pap test is received on the same day; see <i>Diagnostic and Treatment</i> , above.	Nothing	\$25 copay per visit (No deductible)
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	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>	<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 vaccine, annually Pneumococcal vaccine, age 65 and over 	Nothing	Nothing
Preventive care, children		
<ul style="list-style-type: none"> Childhood immunizations recommended by the American Academy of Pediatrics 	Nothing	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) 	\$20 copay per primary care visit \$30 copay per specialist visit	\$25 copay per visit (No deductible)

Maternity care	You pay - High Option	You pay - Standard Option
<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 <i>Services requiring our prior approval in Section 3.</i> • 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. Infant circumcision is covered under the maternity benefit when it is done during the mother's inpatient hospital stay during delivery. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). • We cover 2 routine sonograms per pregnancy to determine fetal age, size or sex. <p>NOTE: We encourage you to participate in our Healthy Pregnancy Program; see <i>Special Features</i> Section.</p>	Nothing	Nothing
Family planning		
<p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • 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>\$20 copay per primary care visit</p> <p>\$30 copay per specialist visit</p> <p>20% of charges per inpatient admission</p> <p>\$50 per outpatient surgery</p>	20% of charges
<p>Voluntary Sterilization</p> <p>Note: We pay voluntary sterilization performed secondary to a Cesarean section under <i>Surgical procedures</i> (See Section 5(b)).</p>	20% of charges per inpatient admission,	20% of charges
<p><i>Not covered: reversal of voluntary surgical sterilization, genetic counseling or testing.</i></p>	<i>All charges.</i>	<i>All charges</i>

Infertility services	You pay - High Option	You pay - Standard Option
Diagnosis and treatment of infertility, such as: Artificial insemination: <ul style="list-style-type: none"> • Intravaginal insemination (IVI) • Intracervical insemination (ICI) • Intrauterine insemination (IUI) 	\$30 per specialist visit 20% of charges per inpatient admission \$50 per outpatient surgery	20% of charges
<i>Not covered:</i> <ul style="list-style-type: none"> • Assisted reproductive technology (ART) procedures, such as: • In vitro fertilization • Embryo transfer, gamete GIFT and zygote ZIFT • Zygote transfer • Services and supplies related to excluded ART procedures • Cost of donor sperm • Cost of donor egg • Fertility drugs • Expenses related to surrogate parenting • Other preservation techniques 	<i>All charges.</i>	<i>All charges</i>
Allergy care		
<ul style="list-style-type: none"> • Testing and treatment • Allergy injection 	\$30 per specialist visit	\$25 copay per visit (No deductible)
Allergy serum	Nothing	Nothing
<i>Not covered: provocative food testing and sublingual allergy desensitization.</i>	<i>All charges.</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 <i>Organ/Tissue Transplants in Section 5(b)</i> . <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 1-800/805-7938 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 in Section 3</i> .	\$30 per specialist visit	20% of charges

Physical, cardiac and occupational therapies	You pay - High Option	You pay - Standard Option
<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 <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 (see <i>Services requiring our Prior Approval in Section 3</i>).</p> <ul style="list-style-type: none"> Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction. 	\$30 per outpatient visit Nothing per visit during covered inpatient admission	20% of charges
<ul style="list-style-type: none"> <i>Not covered:</i> <i>long-term rehabilitative therapy</i> <i>exercise programs</i> 	<i>All charges.</i>	<i>All charges</i>
Speech therapy		
<p>Coverage up to 2 consecutive months per condition by speech therapists (see <i>Services requiring our Prior Approval</i> on page 9).</p>	\$30 per outpatient visit Nothing per visit during covered inpatient admission	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>long term therapy</i> 	<i>All charges.</i>	<i>All charges</i>
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>) 	\$30 per specialist visit	\$25 copay per visit (No deductible)
<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> 	<i>All charges.</i>	<i>All charges</i>
Vision services (testing, treatment, and supplies)		
<p>Eyeglasses or one pair of contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)</p>	\$20 per primary care visit \$30 per specialist visit	\$25 copay per visit (No deductible)
<p>Eye exam including refraction error to determine the need for vision correction for children through age 17 (see <i>Preventive care, children</i>)</p>	\$20 per primary care visit \$30 per specialist visit	\$25 copay per visit (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>surgery for the purpose of modifying or correcting myopia, hyperopia or stigmatic error</i> <i>all other vision services except as described above.</i> 	<i>All charges</i>	<i>All charges</i>

Foot care	You pay - High Option	You pay - Standard Option
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.	\$20 per primary care visit \$30 per specialist	\$25 copay per visit (No deductible)
<i>Not covered:</i> <ul style="list-style-type: none"> • 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 • 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>All charges.</i>	<i>All charges</i>
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 <i>non-dental</i> treatment of temporomandibular joint (TMJ) pain dysfunction syndrome (See <i>Services requiring our prior approval in Section 3.</i>) 	20% of charges	20% of charges
<i>Not covered:</i> <ul style="list-style-type: none"> • orthopedic and corrective shoes • arch supports • foot orthotics • heel pads and heel cups • lumbosacral supports • corsets, trusses, elastic stockings, support hose, and other supportive devices • prosthetic replacements provided less than 3 years after the last one we provided. • Dental appliances of any sort, including but not limited to bridges, braces, and retainers, except those for non-dental treatment of TMJ. • Wigs, scalp hair prosthesis or hair transplants 	<i>All charges.</i>	<i>All charges</i>

Durable medical equipment (DME)	You pay - High Option	You pay - Standard Option
<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</p> <p>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>	<p>20% of charges</p> <p>NOTE: You must obtain prior authorization for supplies/equipment with a retail value of \$200 or more. Failure to obtain prior authorization will result in benefits being paid at the Point of Service benefit level.</p>	<p>20% of charges</p> <p>NOTE: You must obtain prior authorization for supplies/equipment with a retail value of \$200 or more. Failure to obtain prior authorization will result in benefits being paid at the Point of Service benefit level.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Medical supplies/equipment that can be purchased over-the-counter</i> • <i>Household equipment/fixtures, such as air purifiers and ramps</i> • <i>Convenience items</i> • <i>Self-help items</i> • <i>Educational equipment</i> • <i>Communication aids or devices, such as speech processors</i> • <i>Replacement or repair of items, if the items are damaged or destroyed by your misuse, abuse or carelessness, lost, or stolen</i> • <i>Duplicate or similar items</i> • <i>Service call charges, labor charges, charges for repair estimates</i> • <i>Vehicle/car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier</i> 	<p><i>All charges.</i></p>	<p><i>All charges.</i></p>
<p>Home health services</p>		
<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. <p>NOTE: Prior Authorization is required, failure to get prior authorization will result in payment at the point of service level. See <i>Services requiring our prior approval in Section 3.</i></p>	<p>\$20 copay per visit</p>	<p>20% of charges</p>

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Home health services (continued)	You pay - High Option	You pay - Standard Option
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>	<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 and vibratory therapy. NOTE: Office visits are limited to 20 visits per calendar year.	\$20 per visit	\$25 copay per visit (No deductible)
<i>Not covered: Vitamins, minerals, therabands, cervical pillows, traction services, and hot/cold pack application.</i>	<i>All charges.</i>	<i>All charges</i>
Alternative treatments		
<ul style="list-style-type: none"> Acupuncture by a doctor of medicine or osteopathy for anesthesia pain relief. Sleep therapy for central or obstructive apnea when we have approved it. 	\$30 per specialist visit	20% of charges
<i>Not covered:</i> <ul style="list-style-type: none"> <i>biofeedback</i> <i>all other homeopathic or naturopathic services</i> 	<i>All charges</i>	<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 prescription drugs Diabetes self-management from qualified providers for persons who meet plan criteria – limited to no more than two (2) comprehensive education programs per lifetime and up to eight (8) follow-up visits per year will be covered. 	Nothing	Nothing

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

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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.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for Participating Providers is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive in-network benefit coverage.
- 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 PRIOR AUTHORIZATION OF SOME SURGICAL PROCEDURES.** Please refer to the prior authorization information shown in Section 3 to be sure which services require prior authorization and identify which surgeries require prior authorization.

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Benefit Description	You pay – High Option	You pay - Standard Option
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. • Treatment of burns • Voluntary Sterilization (e.g. Tubal ligation, Vasectomy) <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>\$30 per specialist visit</p> <p>\$100 per day copay up to \$500 per inpatient surgery or service</p> <p>\$50 per outpatient surgery or service</p>	<p>\$25 copay per office visit (No deductible)</p> <p>\$100 per day copay up to \$500 per inpatient surgery or service</p> <p>20% of outpatient charges</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> 	<i>All charges.</i>	<i>All charges.</i>

Reconstructive surgery	You pay - High Option	You pay - Standard Option
<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 your 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>\$30 per specialist visit</p> <p>\$100 day copay up to \$500 per inpatient surgery or service</p> <p>\$50 per outpatient surgery or service</p>	<p>\$25 copay per office visit (No deductible)</p> <p>\$100 per day copay up to \$500 per inpatient surgery or service</p> <p>20% of outpatient charges</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, including skin tag removal, except repair of accidental injury.</i> • <i>Surgeries related to sex transformation</i> 	<p><i>All charges.</i></p>	<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. • Surgery to correct TMJ is covered upon radiological determination of pathology (See <i>Services requiring our prior approval in Section 3</i>) 	<p>\$30 per specialist visit</p> <p>\$100 per day copay up to \$500 per inpatient surgery or service</p> <p>\$50 per outpatient surgery or service</p>	<p>\$25 copay per visit (No deductible)</p> <p>\$100 per day copay up to \$500 per inpatient surgery or service</p> <p>20% of outpatient charges</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>	<p><i>All charges</i></p>

Organ/tissue transplants	You pay - High Option	You pay - Standard Option
Limited to: <ul style="list-style-type: none"> • Cornea • Heart • Heart/Lung • Kidney • Kidney/Pancreas • Liver • Intestinal transplants (small intestine) and the small intestine with the liver or small intestine with multiple organs such as the liver, stomach, and pancreas 	Nothing	Nothing
<ul style="list-style-type: none"> • 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 <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 our medical director in accordance with our 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>	Nothing	20% of charges
<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>Autologous tandem transplants</i> • <i>Transplants not listed as covered</i> 	<i>All charges.</i>	<i>All charges.</i>
Anesthesia		
Professional services provided in – <ul style="list-style-type: none"> • Hospital (inpatient) 	Nothing	20% of charges
<ul style="list-style-type: none"> • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office 	Nothing	20% of charges
<i>Not Covered: Hypnotic Anesthesia</i>	<i>All Charges</i>	<i>All charges.</i>

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

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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.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for Participating Providers is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive in-network benefit coverage.
- 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 PRIOR AUTHORIZATION OF NON-EMERGENCY HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior authorization.

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Benefit Description	You pay – High Option	You pay - Standard Option
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 day copay up to \$500 per admission	\$100 per day copay up to \$500 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	Nothing
<i>Not covered:</i> <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 • Admissions to hospitals performed only for the convenience of the member, the member’s family or the member’s physician or other provider • Costs associated with private rooms, above the semi-private room rate 	<i>All charges.</i>	<i>All charges.</i>

Outpatient hospital or ambulatory surgical center	You pay - High Option	You pay - Standard Option
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • 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>	\$50 per visit	20% of charges
<p>Outpatient hospital services:</p> <ul style="list-style-type: none"> • Diagnostic laboratory tests, X-rays, and pathology services • Pre-surgical testing 	Nothing	20% of charges
<i>Not covered: blood and blood derivatives not replaced by you.</i>	<i>All charges.</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 day copay up to \$500 per admission	\$100 per day copay up to \$500 per admission
<i>Not covered: custodial, convalescent, intermediate level or domiciliary care, residential care, rest cures or services to assist in activities of daily living.</i>	<i>All charges.</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	20% of charges
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges.</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. 	\$50 copay	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Transfers to hospitals performed only for the convenience of the member, the member's family or the member's physician or other provider.</i> • <i>Non-emergency services and/or travel, unless pre-approved and arranged by us.</i> 	<i>All charges.</i>	<i>All charges.</i>

Section 5 (d). Emergency services/accidents

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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.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for Participating Providers is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive in-network benefit coverage.
- 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.

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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. We 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 us 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 our service area, a \$100 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 we 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

Emergency services/accidents continue on the next page

- 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 us 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 us 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 – High Option	You pay - Standard Option
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 	\$20 per primary care visit \$30 per specialist visit	\$25 copay per primary care or specialist visit (No deductible)
<ul style="list-style-type: none"> • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$100 per visit, waived if admitted	\$100 per visit, waived if admitted (No deductible).
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges.</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 	\$20 per primary care visit \$30 per specialist visit	\$25 copay per primary care or specialist visit (No deductible)
<ul style="list-style-type: none"> • Emergency care as an outpatient or inpatient at a hospital, including doctors' services 	\$100 per , waived if admitted	\$100 per visit, waived if admitted (No deductible).
<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>	<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.	\$50 copay	20% of charges

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

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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 and are payable only when we determine they are medically necessary.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for Participating Providers is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive in-network benefit coverage.
- 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.

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Benefit Description	You Pay – High Option	You pay - Standard Option
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.	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. 	\$30 per specialist outpatient visit	\$25 per visit (No deductible)
<ul style="list-style-type: none"> • Diagnostic tests 	Nothing	20% of charges
<ul style="list-style-type: none"> • Services provided by a hospital or other facility 	\$100 per day copay up to \$500 per inpatient admission	\$100 per day copay up to \$500 per admission
<i>Not covered:</i> <ul style="list-style-type: none"> • Marriage counseling • Family counseling • Bereavement counseling • Pastoral counseling • Financial counseling • Legal counseling • Custodial care counseling • Services we have not approved. 	<i>All charges.</i>	<i>All charges.</i>

Prior approval

To be eligible to receive these benefits you must obtain a treatment plan and follow the authorization processes: Contact our Health Services Department for the prior authorization process for elective inpatient hospitalizations, non urgent care, pharmaceutical decisions, behavioral health, urgent/emergency conditions, concurrent review and retrospective review (post-service) contact our Health Services Department, available between the hours of 8:00a.m. and 5:00p.m. Central Time, Monday through Friday, by calling our toll-free number 1-800-805-7938 or (650)328-6807. After hours you may leave a message on the confidential voice mail of the Health Services Department and someone will return your call. You are ultimately responsible for obtaining prior authorization from the Health Services Department. Failure to obtain prior authorization will result in a reduction to the Out of Network benefits level. However, information provided by the physician’s office also satisfies this requirement.

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

Section 5 (f). Prescription drug benefits

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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.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for Participating Providers is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers, there are no Point of Service (out-of-network) benefits.
- 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.

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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 must fill the prescription at a network pharmacy. If you choose to go to a non-network pharmacy, you must pay 100% of the costs of the medication to the pharmacy (except in an emergency). Some injectible drugs are obtained through mail order, For more information call Member Services at 605/328-6800 for a copy of the Prescription Drug Brochure. To enroll and obtain prior-approval to join the Injectible Drugs Program call 1-800/278-0980.
- **How you can obtain them.** You must present your prescription ID card to your pharmacy, if you do not present your prescription ID card to your pharmacy, you must pay 100% of the costs of the medication to the pharmacy (except in an emergency).
- **We use a formulary.** However, we have an open 3-tiered 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 or 1-800/752-5863 or go to the Express Scripts website at www.sioxvalley.org/HealthPlan.
- **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.

Prescription drugs continue on the next page

Benefit Description	You pay – High Option	You pay - Standard Option
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan:</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>. • Drugs for sexual dysfunction limited per policy guidelines. Contact the Plan for details. Viagra limited to 4 pills per month. (see Section 3, <i>Services requiring our prior approval</i>). • Contraceptive drugs and devices • Human Growth Hormones (see Section 3, <i>Services requiring our prior approval</i>). • Self Administered Injectable drugs 	<p>\$15 per formulary generic drug \$30 per formulary brand name drug \$50 per non-formulary brand name drug.</p> <p>NOTE: If you request that you receive the brand name drug when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic in addition to your copay.</p>	<p>\$15 per formulary generic drug \$30 per formulary brand name drug \$50 per non-formulary brand name drug. (No deductible)</p> <p>NOTE: If you request that you receive the brand name drug when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic in addition to your copay.</p>
<p>Diabetic Drugs/Supplies</p> <ul style="list-style-type: none"> • Blood glucose monitors • Insulin injection aids • Insulin pumps and all supplies for pump • Insulin infusion devices • Prescribed oral agents for controlling blood sugars • Lancets and lancet devices • Blood/urine testing strips (maximum of 200 strips per month supply) • Glucose agents • Glucagon kits • Syringes for the administration of covered medications • Prescription drugs for smoking cessation up to a 3-month supply per calendar year 	<p>\$15 copay per 30 day supply for each individual item</p>	<p>\$15 copay per 30 day supply for each individual item (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes including baldness and 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>Medication available over the counter (OTC)</i> • <i>Orthomolecular therapy including nutrients, vitamins</i> • <i>B-12 injections, except for pernicious anemia</i> • <i>Compound medications with no legend medication</i> • <i>Acne medication for members over age thirty-five</i> 	<p><i>All charges.</i></p>	<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 our TTY line at 605/328-6869.
Pregnancy Program	Individuals may contact the Healthy Pregnancy Program at 1-800/752-5863 to enroll.
Centers of Excellence	We utilize the contracted Centers of Excellence Network for transplant services. Please contact us at 605/328-6807 for any information needed.

Section 5 (h). Dental benefits

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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.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for Participating Providers is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive in-network benefit coverage.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5 (c) for inpatient hospital benefits. 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.

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Accidental injury benefit	You pay - High Option	You pay - Standard Option
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth (this does not include replacements including crowns, bridges or implants) as long as the patient was covered under the plan during the time of the injury or illness causing the damage and receives care within six (6) months of the occurrence. The need for these services must result from an accidental injury or cancer.	\$30 per specialist visit \$50 per outpatient surgery \$100 per day copay up to \$500 per inpatient admission	20% of charges for specialist visit or outpatient surgery \$100 per day copay up to \$500 per inpatient admission
Dental Benefits		
<ul style="list-style-type: none"> • Dental service required for cancer that damages sound natural teeth. • Associated radiology services 	\$30 per specialist visit \$50 per outpatient surgery \$100 per day copay up to \$500 per inpatient admission	20% of charges for specialist visit or outpatient surgery \$100 per day copay up to \$500 per inpatient admission
We have no other dental benefits		

Section 5 (i). Point of service benefits

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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.
- **Under High Option**, the calendar year deductible is \$500 per person and \$1,000 per family.
- **Under Standard Option**, the calendar year deductible for Non-Participating Providers is \$1,000 per person and \$3,000 per family. The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- 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.

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Facts about this Plan's POS option

You may choose to obtain benefits covered by our 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 be received by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without authorization from us, 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 (No deductible)
- 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;
- Services list as not covered at the in-network level in Section 5;
- 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.

Under High and Standard Options, 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.

Ambulance and other transportation services

Under High Option, 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.

Under Standard Option, you pay 40% 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 you must pay at the time services are received before we will pay for such services.

Under High Option, the calendar year deductible is \$500 per person and \$1,000 per family for Non-Participating Providers.

Under Standard Option, the calendar year deductible for Non-Participating Providers is \$1,000 per person and \$3,000 per family. The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.

Coinsurance

Coinsurance is the percentage of charges to be paid by you for services at the time such services are rendered. Our 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.

Catastrophic Protection Out-of-pocket maximum

The catastrophic limit on your 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). Your out-of-pocket expenses under POS qualify for our catastrophic protection out-of-pocket maximum.

Hospital/extended care

We 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 \$100 per day copay up to \$500 per inpatient admission, but the copay is waived for true emergency admissions.

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. We will need a claim from you, 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* in Section 3.

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;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service; and;
- Health Care Services performed by any Provider who is a Member of the enrollee's immediate family, including any person normally residing in the member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area.

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 services you receive outside of our service area -- 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> <ul style="list-style-type: none">(a) Write to us within 6 months from the date of our decision; and(b) Send your request to us at: Sioux Valley Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110;(c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and(d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none">(a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or(b) Write to you and maintain our denial -- go to step 4; or(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.
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 more than one claim, 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.

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 prior authorization. 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 may 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 or a covered family member have coverage 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. All plan benefits and visit limitations are taken into consideration even if benefits are coordinated. Visits and corresponding claims are denied once they go beyond plan maximum limits.

•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.

• Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or both Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket

expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

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.

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 claim will be coordinated automatically and we will then provide secondary benefits for the balance of covered charges. You will not need to do anything. To find out if you need to do something to file your claims, call us at 605/328-6800 or 1-800/752-5863.

We do not waive any costs when you have Medicare.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare 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. *Please note, if your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.*

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
Are an active employee with the Federal government and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
Are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
• You have FEHB coverage through your spouse who is an active employee		✓
Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case)	✓*	
Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
You have FEHB coverage through your spouse who is an annuitant	✓	
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)	✓*	
Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
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)	✓**	
B. When you or a covered family member...		
Have Medicare solely based on end stage renal disease (ESRD) and... • It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
Become eligible for Medicare due to ESRD while already a Medicare beneficiary and... • This Plan was the primary payer before eligibility due to ESRD		✓ for 30-month coordination period
Medicare was the primary payer before eligibility due to ESRD	✓	
C. When either you or your spouse are eligible for Medicare solely due to disability and you		
Are an active employee with the Federal government and... • You have FEHB coverage on your own or through your spouse who is also an active employee		✓
You have FEHB coverage through your spouse who is an annuitant	✓	
Are an annuitant and... • You have FEHB coverage on your own or through your spouse who is also an annuitant	✓	
You have FEHB coverage through your spouse who is an active employee		✓
D. Are covered under the FEHB Spouse Equity provision as a former spouse	✓	

* Unless you have FEHB coverage through your spouse who is an active employee. ** Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

- **Medicare managed care plan** If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from 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 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 and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. If TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) 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 under the program.

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 providers.

Medicaid

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

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a one of these State programs, eliminating your FEHB 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 under the State program.

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.

We will provide health care services to you for the illness or injury, just as we would in any other case. However, if you accept the services from us, this acceptance constitutes your consent to the subrogation provisions discussed above.

Member's Responsibilities

You must take such action, furnish such information and assistance, and execute such instruments as we may require to facilitate enforcement of our rights under this provision. You shall take no action prejudicing the rights and interests of the Plan under this provision. If you fail to cooperate in our administration of this subrogation provision, you be responsible for the Usual and Reasonable Charges for services subject to this Part and any legal costs incurred by the Plan to enforce our 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 <i>Section 4</i> .
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See <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 <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 or type, frequency, level, setting, and duration, to your 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 your health; or• Prevent deterioration of your 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 your FEHB coverage. These materials tell you:

- 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.

Children's Equity Act

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the Federal Employees Health Benefits (FEHB) Program, if you are

an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option,
- if you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- if you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot make any changes after retirement. Contact your employing office for further information.

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 (TCC), or a conversion policy (a non-FEHB individual policy).

• 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. This is the case even when the court has ordered your former spouse to supply health coverage to you. But, you may be eligible for your own FEHB coverage under the spouse equity law or Temporary Continuation of Coverage (TCC). 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. You can also download the guide from OPM's website, www.opm.gov/insure.

• 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.

Two new Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you know about two new Federal programs that complement the FEHB Program. First, the **Flexible Spending Account (FSA) Program**, also known as **FSAFEDS**, lets you set aside tax-free money to pay for health and dependent care expenses. The result can be a discount of 20 to more than 40 percent on services you routinely pay for out-of-pocket. Second, the **Federal Long Term Care Insurance Program (FLTCIP)** covers long term care costs not covered under the FEHB.

The Federal Flexible Spending Account Program - *FSAFEDS*

- **What is an FSA?**

It is a tax-favored benefit that allows you to set aside pre-tax money from your paychecks to pay for a variety of eligible expenses. By using an FSA, you can reduce your taxes while paying for services you would have to pay for anyway, producing a discount that can be over 40%!!

There are two types of FSAs offered by the FSAFEDS Program:

Health Care Flexible Spending Account (HCFSA)

- Covers eligible health care expenses not reimbursed by us, or any other medical, dental, or vision care plan you or your dependents may have
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified dependent under the U.S. Internal Revenue Service (IRS) definition and/or with whom you jointly file your Federal income tax return, even if you don't have self and family health benefits coverage. **Note:** The IRS has a broader definition than that of a "family member" than is used under the FEHB Program to provide benefits by your FEHB Plan.
- The maximum amount that can be allotted for the HCFSA is \$3,000 annually. The minimum amount is \$250 annually.

Dependent Care Flexible Spending Account (DCFSA)

- Covers eligible dependent care expenses incurred so you can work, or if you are married, so you and your spouse can work, or your spouse can look for work or attend school full-time.
- Eligible dependents for this account include anyone you claim on your Federal income tax return as a qualified IRS dependent and/or with whom you jointly file your Federal income tax return.
- The maximum that can be allotted for the DCFSA is \$5,000 annually. The minimum amount is \$250 annually. **Note:** The IRS limits contributions to a Dependent Care FSA. For single taxpayers and taxpayers filing a joint return, the maximum is \$5,000 per year. For taxpayers who file their taxes separately with a spouse, the maximum is \$2,500 per year. The limit includes any child care subsidy you may receive

- **Enroll during Open Season**
Season.

You **must make an election** to enroll in an FSA during the FEHB Open

even if you enrolled during the initial Open Season for 2003, you must make a new election to continue participating in 2004. Enrollment is easy!

- Enroll online anytime during Open Season (November 10 through December 8, 2003) at www.fsafeds.com.
- Call the toll-free number 1-877-FSAFEDS (372-3337) Monday through Friday, from 9 a.m. until 9 p.m. eastern time and a FSAFEDS Benefit Counselor will help you enroll.

What is SHPS?

SHPS is a third-party administrator hired by OPM to manage the FSAFEDS Program. SHPS is the largest FSA administrator in the nation and will be

responsible for enrollment, claims processing, customer service, and day-to-day operations of FSAFEDS.

Who is eligible to enroll?

If you are a Federal employee eligible for FEHB – even if you’re not enrolled in FEHB– you can choose to participate in either, or both, of the flexible spending accounts. If you are not eligible for FEHB, you are not eligible to enroll for a Health Care FSA. However, almost all Federal employees are eligible to enroll for the Dependent Care FSA. The only exception is intermittent (also called when actually employed [WAE]) employees expected to work less than 180 days during the year.

Note: FSAFEDS is the FSA Program established for all Executive Branch employees and Legislative Branch employees whose employers signed on. Under IRS law, FSAs are not available to annuitants. In addition, the U.S. Postal Service and the Judicial Branch, among others, are Federal agencies that have their own plans with slightly different rules, but the advantages of having an FSA are the same no matter what agency you work for.

- **How much should I contribute to my FSA?**

Plan carefully when deciding how much to contribute to an FSA. Because of the tax benefits of an FSA, the IRS places strict guidelines on them. You need to estimate how much you want to allocate to an FSA because current IRS regulations require you forfeit any funds remaining in your account(s) at the end of the FSA plan year. This is referred to as the “use-it-or-lose-it” rule. You will have until April 29, 2004 to submit claims for your eligible expenses incurred during 2003 if you enrolled in FSAFEDS when it was initially offered. You will have until April 30, 2005 to submit claims for your eligible expenses incurred from January 1 through December 31, 2004 if you elect FSAFEDS during this Open Season.

The **FSAFEDS Calculator** at www.fsafeds.com will help you plan your FSA allocations and provide an estimate of your tax savings based on your individual situation.

- **What can my HCFSA pay for?**

Every FEHB health plan includes cost sharing features, such as deductibles you must meet before the Plan provides benefits, coinsurance or copayments that you pay when you and the Plan share costs, and medical services and supplies that are not covered by the Plan and for which you must pay. These out-of-pocket costs are summarized on page 10 and detailed throughout this brochure. Your HCFSA will reimburse you for such costs when they are for tax deductible medical care for you and your dependents that is NOT covered by this FEHB Plan or any other coverage that you have.

Under both the High and Standard Options of this Plan, typical out-of-pocket expenses include: coinsurance for inpatient admissions related to family planning, diagnosis and treatment of infertility, and vision services. However, three common but significant expenses not covered by the Plan also includes reversal of voluntary sterilization, in-vitro fertilization, and laser surgery to correct myopia, hyperopia or stigmatic error.

The IRS governs expenses reimbursable by a HCFSA. See Publication 502 for a comprehensive list of tax-deductible medical expenses. **Note: While you will see insurance premiums listed in Publication 502, they are NOT a reimbursable expense for FSA purposes.** Publication 502 can be found on the IRS Web site at <http://www.irs.gov/pub/irs-pdf/p502.pdf>. If you do not see your service or expense listed in Publication 502, please call a FSAFEDS Benefit Counselor at 1-877-FSAFEDS (372-3337), who will be able to answer your specific questions.

- **Tax savings with an FSA**

An FSA lets you allot money for eligible expenses *before* your agency deducts taxes from your paycheck. This means the amount of income that your taxes are based on will be lower, so your tax liability will also be lower. Without an FSA, you would still pay for these expenses, but you would do so using money remaining in your paycheck after Federal (and often state and local) taxes are deducted. The following chart illustrates a typical tax savings example:

Annual Tax Savings Example	With FSA	Without FSA
If your taxable income is:	\$50,000	\$50,000
And you deposit this amount into a FSA:	\$ 2,000	-\$0-
Your taxable income is now:	\$48,000	\$50,000
Subtract Federal & Social Security taxes:	\$13,807	\$14,383
If you spend after-tax dollars for expenses:	-\$0-	\$ 2,000
Your real spendable income is:	\$34,193	\$33,617
Your tax savings:	\$576	-\$0-

Note: This example is intended to demonstrate a typical tax savings based on 27% Federal and 7.65% FICA taxes. Actual savings will vary based upon in which retirement system you are enrolled (CSRS or FERS), as well as your individual tax situation. In this example, the individual received \$2,000 in services for \$1,424, a discount of almost 36%! You may also wish to consult a tax professional for more information on the tax implications of an FSA.

- **Tax credits and deductions**

You *cannot* claim expenses on your Federal income tax return if you receive reimbursement for them from your HCFSA or DCFSA. Below are some guidelines that may help you decide whether to participate in FSAFEDS.

Health care expenses

The HCFSA is tax-free from the first dollar. In addition, you may be reimbursed from the HCFSA at any time during the year for expenses up to the annual amount you've elected to contribute.

Only health care expenses exceeding 7.5% of your adjusted gross income are eligible to be deducted on your Federal income tax return. Using the example listed in the above chart, only health care expenses exceeding \$3,750 (7.5% of \$50,000) would be eligible to be deducted on your Federal income tax return. In addition, money set aside through a HCFSA is also exempt from FICA taxes. This exception is not available on your Federal income tax return.

Dependent care expenses

The DCFSA generally allows many families to save more than they would with the Federal tax credit for dependent care expenses. Note that you may only be reimbursed from the DCFSA up to your current account balance. If you file a claim for more than your current balance, it will be held until additional payroll allotments have been added to your account.

Visit www.fsafeds.com and download the Dependent Care Tax Credit Worksheet from the Quick Links box to help you determine what is best for your situation. You may also wish to consult a tax professional for more details.

- **Does it cost me anything to participate in FSAFEDS?**

Probably not. While there is an administrative fee of \$4.00 per month for an HCFSAs and 1.5% of the annual election for a DCFSAs, most agencies have elected to pay these fees out of their share of employment tax savings. To be sure, check the FSAFEDS.com web site or call 1-877-FSAFEDS (372-3337). Also, remember that participating in FSAFEDS can cost you money if you don't spend your entire account balance by the end of the plan year and wind up forfeiting your end of year account balance, per the IRS "use-it-or-lose-it" rule.

- **Contact us**

To find out more or to enroll, please visit the **FSAFEDS Web site** at www.fsafeds.com, or contact SHPS by email or by phone. SHPS Benefit Counselors are available from 9:00 a.m. until 9:00 p.m. eastern time, Monday through Friday.

- E-mail: fsafeds@shps.net
- Telephone: 1-877-FSAFEDS (372-3337)
- TTY: 1-800-952-0450 (for hearing impaired individuals that would like to utilize a text messaging service)

The Federal Long Term Care Insurance Program

It's important protection

Here's why you should consider enrolling in the Federal Long Term Care Insurance Program:

- **FEHB plans do not cover the cost of long term care.** Also called "custodial care," long term care is help you receive when you need assistance performing activities of daily living – such as bathing or dressing yourself. This need can strike anyone at any age and the cost of care can be substantial.
- **The Federal Long Term Care Insurance Program can help protect you from the potentially high cost of long term care.** This coverage gives you control over the type of care you receive and where you receive it. It can also help you remain independent, so you won't have to worry about being a burden to your loved ones.
- **It's to your advantage to apply sooner rather than later.** Long term care insurance is something you must apply for, and pass a medical screening (called underwriting) in order to be enrolled. Certain medical conditions will prevent some people from being approved for coverage. By applying while you're in good health, you could avoid the risk of having a change in health disqualify you from obtaining coverage. Also, the younger you are when you apply, the lower your premiums.
- **You don't have to wait for an open season to apply.** The Federal Long Term Care Insurance Program accepts applications from eligible persons at any time. You will have to complete a full underwriting application, which asks a number of questions about your health. However, if you are a new or newly eligible employee, you (and your spouse, if applicable) have a limited opportunity to apply using the abbreviated underwriting application, which asks fewer questions. If you marry, your new spouse will also have a limited opportunity to apply using abbreviated underwriting. Qualified relatives are also eligible to apply with full underwriting.

To find out more and to request an application

Call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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

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Summary of benefits for the *Sioux Valley Health Plan 2004 High Option*

- **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 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: \$20 primary care; \$30 specialist visit	12
Services provided by a hospital: • Inpatient • Outpatient Surgery • Outpatient Hospital Services • Outpatient Rehabilitative Services (cardiac rehab, physical, occupational, and speech therapies)	\$100 per day copay up to \$500 per admission \$50 per visit Nothing \$30 per outpatient visit	23 24 24 16
Emergency benefits: • In-area • Out-of-area	\$100 per visit; waived if admitted \$100 per visit; waived if admitted	25 25
Mental health and substance abuse treatment.....	Regular cost sharing.	27
Prescription drugs (30 day supply): Generic drugs Formulary brand name drugs Non-formulary brand name drugs	\$ 15 copay \$ 30 copay \$ 50 copay NOTE: If there is no generic equivalent available, you will still have to pay the brand name copay.	29
Dental Care	No benefit.	31
Vision Care (Eye exams for children through age 17.)	\$30 copay	13
Special features: 24 hour nurse line, Services for deaf and hearing impaired, Healthy Pregnancy Program, Centers of Excellence for transplants		30
Point of Service benefits -- Yes		32
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$4,000/Self Only or \$4,000/Family enrollment per year Any costs above reasonable and customary charges do not count toward this protection.	10

Summary of benefits for the *Sioux Valley Health Plan 2004 Standard Option*

- **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 by Plan physicians, except in emergencies.

Benefits	You Pay	Page
Medical services provided by physicians: <ul style="list-style-type: none"> • Diagnostic and treatment services provided in the office 	Office visit copay: \$25 primary care; \$25 specialist	12
Services provided by a hospital: <ul style="list-style-type: none"> • Inpatient • Outpatient Surgery • Outpatient Hospital Services..... • Outpatient Rehabilitative Services (cardiac rehab, physical, occupational, and speech therapies)..... 	\$100 per day copay up to \$500 per admission 20% coinsurance Nothing 20% coinsurance	23 24 24 16
Emergency benefits: <ul style="list-style-type: none"> • In-area • Out-of-area..... 	\$100 per visit; waived if admitted \$100 per visit; waived if admitted	25 25
Mental health and substance abuse treatment.....	Regular cost sharing.	27
Prescription drugs (30 day supply): <ul style="list-style-type: none"> Generic drugs..... Formulary brand name drugs..... Non-formulary brand name drugs..... 	\$ 15 copay \$ 30 copay \$ 50 copay NOTE: If there is no generic equivalent available, you will still have to pay the brand name copay.	29
Dental Care	No benefit.	31
Vision Care	\$25 per visit	13
(Eye exams for children through age 17.)		
Special features: 24 hour nurse line, Services for deaf and hearing impaired, Healthy Pregnancy Program, Centers of Excellence for transplants		30
Point of Service benefits -- Yes		32
Protection against catastrophic costs (your catastrophic protection out-of-pocket maximum)	Nothing after \$3,000/Self Only or \$5,000/Family enrollment per year Any costs above reasonable and customary charges do not count toward this protection.	10

2004 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 a special FEHB guide is published 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 and Northwestern Iowa

High Option Self Only	AU1	\$121.40	\$92.26	\$263.03	\$199.90	\$143.23	\$70.34
High Option Self and Family	AU2	\$277.09	\$214.16	\$600.36	\$494.02	\$327.12	\$164.13
Standard Option Self Only	AU4	\$121.40	\$59.92	\$263.03	\$129.83	\$143.23	\$38.00
Standard Option Self and Family	AU5	\$277.09	\$139.74	\$600.36	\$302.77	\$327.12	\$89.71