2013

CERTIFICATE OF COVERAGE

SD Fully Insured Non-Grandfathered
Effective Jan. 1, 2013

Avera Health Plans

1 (888) 322-2115 • www.AveraHealthPlans.com

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Welcome to Avera Health Plans

Avera Health Plans provides benefits that are designed to keep you healthy as well as provide care for you in case of illness or injury. This book, your Certificate of Coverage, explains your benefits according to the laws of the state of South Dakota. Please review this book carefully so you can take advantage of your benefits.

We're Here for You

Call Us

Monday -- Friday, 8 a.m. to 5 p.m. CT
(605) 322-4545 or toll-free at 1 (888) 322-2115

Write or Fax Us

Avera Health Plans
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538
Our fax number is: (605) 322-4540

E-mail Us

service@AveraHealthPlans.com

Visit Our Website

Visit us online at **www.AveraHealthPlans.com** to access the following:

- Provider directory – search for participating providers by name, city and state or by a specialty
- Claims and eligibility information
- Requesting a member identification card
- Benefit Summary
- Preventive benefits
- Prescription drug formulary
- Newsletter
- My 365 – your personal health and wellness guide
- Rights and privacy information

How to Use This Book

How to Find Information

- Scan the Table of Contents if you are looking for a general subject (for example, looking for a provider, how to file a claim).
- See your Benefit Summary for a list of the most common benefits and how much you pay for these health services.
- Pay special attention to the section, What Is Covered and Not Covered.

For the purposes of this book:

- **You and Your** means you and your family members eligible under this Certificate of Coverage.
- **We, Us** and **Our** refers to Avera Health Plans.

Helpful Symbols

The following symbols indicate special information:

ALERT

Important information you should know or something you need to do.

TIP

Information that may be important in understanding a subject.

FOR MORE INFORMATION

Refers to information found elsewhere.

Definitions

Allowed Amount means the amount payable for a covered service or supply. The allowed amount for:

- Participating providers is a negotiated contract amount.
- Non-participating providers is:
  - an amount established by us using various methodologies for non-emergency health services or
  - an amount established using various methodologies as described by federal guidance for emergency health services.

Benefit Summary is a document listing what you pay under your benefit plan for some of your covered health services.

Calendar Year means January 1 through December 31.

Caregiver means a person not associated with the hospice agency who resides in the home and provides non-medical services and companionship. This may be a family member.

Certificate of Coverage means this contract, Benefit Summary, amendments and attachments that outline your benefits under this Plan.

Covered Health Services means medical diagnostic tests, treatments and supplies that are medically necessary and are listed as covered health services in this Certificate of Coverage.

Creditable Coverage means benefits or coverage provided under:

- Medicare or Medicaid,
- An employer-based health insurance plan or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a health benefit plan,
- An individual health insurance policy,
- Chapter 55 of Title 10, United States Code which provides coverage for medical and dental care for members and their dependents and former members of the uniformed services,
- A medical care program of the Indian Health Service or of a tribal organization,
- A state health benefits risk pool,
- A federal health benefits risk pool,
- A Federal Employee Health Benefit Plan (FEHBP),
- A public health plan,
- A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504)(e),
- A short-term limited-duration policy,
- A college plan or
- A church plan.

Custodial Parent means the parent awarded custody of a child by a court decree. If there is no court decree, the custodial parent will be the one the child lives with for more than one-half of the year, regardless of temporary visitation.

Dependent means the spouse and any dependent child of a subscriber. Dependent Child means:

- The subscriber's biological child,
- A child lawfully adopted by the subscriber or in the process of being adopted, from the date of placement,
- A stepchild of the subscriber or
- A child for whom the subscriber has been granted legal custody.

Developmental Care means health services, regardless of where or by whom they are provided, which:

- Are provided to a member who has not previously reached the level of development expected for the member's age in the following areas of major life activity:
  - intellectual,
  - physical,
  - receptive and expressive language,
  - learning,
  - mobility,
  - self-direction,
  - capacity for independent living,
  - economic self-sufficiency,
- Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness) or
- Are educational in nature.

Care for congenital defects or birth defects is not considered to be developmental care.

Our medical staff or a qualified party or entity selected by us will determine what health services are developmental care. When a confinement, visit or other health service is found to be primarily for developmental care, some health services (such as prescription drugs, X-rays and lab tests) may still be covered if medically necessary and otherwise covered by the Certificate of Coverage. All bills should be routinely submitted to Avera Health Plans for consideration.

Donor means a person who donates a body organ, including bone marrow or cornea, for transplant procedures.

Drug Formulary means a list of prescription medications under a benefit plan, which are approved for use for specific treatments and dispensed through participating pharmacies to members.

Emergency or Emergency Medical Condition means a medical or behavioral condition that is sudden and has unexpected symptoms of sufficient severity which could not be foreseen by the member, including but not limited to severe pain, that an ordinarily prudent layperson, who

possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

- Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy,
- In the case of a behavioral condition, placing the health of the individual or others in serious jeopardy,
- Serious impairment to bodily function,
- Serious dysfunction or disfigurement of any bodily organ or part,
- Death or
- Left untreated or unattended until regular office hours would result in hospitalization or medical disability.

End-Stage Renal Disease (ESRD) means the Centers for Medicare and Medicaid Services classification of patients with advanced kidney disease or renal impairment.

Group means an employer or other entity under which a number of employees and their dependents, or members of a standardized group, such as a union, are insured under this Certificate of Coverage.

Health Care Services means any medical procedures, diagnoses, facilities or supplies furnished to a member for the evaluation, diagnosis or treatment of pregnancy, illness or injury.

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

The term hospital specifically excludes rest homes, places which are primarily for the care of convalescents, nursing homes, skilled nursing facilities, intermediate care facilities, halfway houses, health resorts, clinics, doctors' offices, private homes, ambulatory surgical centers, residential or transitional living centers or similar facilities.

Hospitalization means an admission as an inpatient in a hospital. Each day of hospitalization includes an overnight stay for which a charge is customarily made.

Individual Benefit Management Program means a contract between us, you and your providers necessary to meet your care needs in a case specific plan. This contract allows for individual consideration of alternate benefits.

In-Network means the highest level of benefits provided when you receive health services from a participating provider.

Investigational, Experimental and Unproven means services, supplies, drugs, treatments or technologies that have not met our evidence-based standards for safety and effectiveness as determined by our medical director, qualified party or other appointed entity. These evidence-based standards may include:

- Approval by an appropriate regulatory authority for general use,
- Scientific evidence from published, peer-reviewed medical literature establishing the safety and/or efficacy, patient selection criteria and proof of improved health outcomes,
- The service, supply or technology is at least as effective as existing alternatives,
- Health outcome improvements obtained in the study setting are reproducible in the community setting or
- Must not be subject to institutional review board oversight or approval.

Health services that are covered under a member's Certificate of Coverage and are not investigational, experimental or unproven are only available for coverage if they have also been determined to be medically necessary for that individual.

Medically Necessary means health services which have been determined by our medical director to be of value in the care of a specific member. To be medically necessary a health service must:

- Not be investigational, experimental or unproven,
- Be used to diagnose or treat a member's condition caused by disease, injury or congenital malformation,
- Be provided at the most appropriate site and at the most appropriate level of service for the member's medical condition,
- On an ongoing basis, have a reasonable probability of:
  - Correcting a significant congenital malformation or disfigurement caused by disease or injury,
  - Preventing significant disease or malformation,
  - Substantially improving a life-sustaining bodily function impaired by disease or injury.
- Not be provided solely to improve a member's condition beyond normal variations in individual development and aging including:
  - Comfort measures in the absence of disease or injury,
  - Improving physical appearance that is within normal individual variation.
- Not be for the sole convenience of the provider, member or member's family.

Member means any individual who is covered under this Certificate of Coverage.

Non-Participating Provider means physicians, hospitals, facilities, institutions, agencies and pharmacies that have not signed a contract with us to provide health services to members. Some health services are not covered if they are received from a non-participating provider.

Out-of-Network means the lowest level of benefits when you receive health services from a non-participating provider. Some health services are not covered if they are received from a non-participating provider.

Participating Provider means physicians, hospitals, facilities, institutions, agencies and pharmacies that have signed a contract with us to provide health services to members.

Plan means the benefit program the group offered to you as an eligible employee through your employment.

Plan Year is a 12-month period of time set by your employer. A plan year usually begins January 1 and ends December 31.

Provider means any physician, group of physicians, hospital or any other institution or entity that furnishes health care services and is licensed or otherwise authorized to render such services in the state where care is provided.

Physician means a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC). For the purpose of this Certificate of Coverage, physician also means any other licensed health care professional who performs a health service which is payable under the Certificate of Coverage.

Premium means the monthly amount paid to us for your coverage under this Certificate of Coverage.

Primary Care Physician means a provider who is a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP) or physician assistant (PA). Your Primary Care Physician should be your first contact for all non-emergency health care needs.

Primary Care Physicians are available in the fields of:

- Family Practice,
- Internal Medicine,
- General Practice,
- Obstetrics and Gynecology and
- Pediatrics

Respite Care means short-term inpatient hospice stays necessary for the member in order to give temporary relief to a hospice member's caregiver who regularly assists with home care.

Service Area means the geographical area approved by the appropriate state regulating agency in which Avera Health Plans may do business.

Skilled Nursing Facility means an institution or that part of an institution which provides skilled nursing care and is certified as a skilled nursing facility under Medicare.

Specialist means any physician who has a specific practice of medical care other than primary care.

Spouse means the subscriber's spouse under the laws of this state.

State means the state of South Dakota.

Subscriber means the primary cardholder for his or her group insurance. A subscriber is also a member.

We, Us and Our refers to Avera Health Plans.

You and **Your** means you and your family members eligible under this Certificate of Coverage.

What I Need to Know as an Avera Health Plans Member

What Are My Rights and Responsibilities?

We will work together with you and your providers as partners to ensure you receive the best possible medical care. To achieve this goal, you should know your rights and responsibilities.

You have the right to:

- Not be discriminated against because of age, gender, cultural background, educational or economic status, religious or sexual orientation or mental or physical disability.
- Make recommendations regarding our Member Rights and Responsibilities policy.
- Not have genetic information used to determine eligibility, coverage, underwriting or premiums or to have genetic information used as a pre-existing condition.
- Timely, proper medical care without discrimination of any kind, regardless of health status or condition.
- Be treated with respect and dignity.
- Receive advice or assistance in a prompt, courteous and responsible manner.
- Privacy during consultation and treatment.
- Confidentiality. We will protect your medical records and personal information.
- Information about the diagnosis, treatment and expected outcomes in terms that you understand. If your provider determines that the information could be harmful to you, the information will be given to a person designated by you or someone with legal authority.
- Information about your plan, participating providers and other health care professionals providing care.
- Discuss concerns or complaints about the care received with those responsible for the care provided, or with us, and to receive a response within a reasonable time period. You also have the right to file a complaint or appeal about us or care provided by providers.
- Participate in decisions with your providers about your health care. You should receive enough information to make an informed decision before receiving any treatment. The information should include the specific procedures or treatment, medical alternatives and associated risks regardless of the cost or benefit coverage.
- Have a guardian, next of kin or legally authorized person exercise rights on your behalf if a medical condition makes you incapable of understanding or exercising your rights.
- Designate any primary care provider who participates in our network and who is available to accept you or your family members.
- Designate a pediatrician as the primary care provider for your children.
- Obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology without a referral.

You have the responsibility to:

- Confirm your provider is participating in our network before every service in order to receive the best benefit possible.
- Treat all Avera Health Plans and provider staff and other members with respect and courtesy.
- Give your providers complete information about your health to get the best possible care. If you don't understand, have questions or disagree with the treatment plan, you have the responsibility to discuss your concerns with the treatment staff and understand their explanations and instructions.
- Carry your Avera Health Plans member ID card at all times and never permit anyone else to use it.
- Show your Avera Health Plans member ID card to all providers. Also bring a picture ID to identify yourself.
- Follow your provider's instructions about your health care. Participate with your providers in making decisions about your health care.
- Pay your deductible or coinsurance promptly.
- Pay your co-pay when you receive services.
- Review and follow this Certificate of Coverage to receive your best benefits.
- Promptly notify us of any changes such as address changes or changes in family status due to marriage, birth, adoption or divorce.
- Provide complete and true information when completing your enrollment application.

What I Pay for Medical Services

What Are the Levels of Coverage?

In-network coverage means the highest level of benefits provided when you receive health services from a participating provider.

Out-of-network coverage means the lowest level of benefits when you receive health services from a non-participating provider. Some health services are not covered if they are received from a non-participating provider.

What Is a Medical Deductible?

A medical deductible is a fixed-dollar amount you pay each year before we begin paying for most benefits. Your medical deductible amount is on your Benefit Summary.

For example:
(a) If your deductible is $1,000, you are responsible for paying the first $1,000 to providers for health services.
(b) After you have paid $1,000, you have met your deductible and then we start paying as described in your Benefit Summary.

You may have an in-network and out-of-network deductible which add up separately. After you pay the deductible, we begin to pay benefits for your covered health services as listed on your Benefit Summary.

Does Everything Count Toward My Medical Deductible?

No, the following out-of-pocket expenses do not count toward your medical deductible:

- Health services you pay for that are not covered by us or health services that exceed benefit limits,
- Health services that are not covered because you did not comply with medical review or pre-certification requirements,
- Cost for non-participating provider charges that exceed our allowed amount,
- Prescription drug co-pays and coinsurance and
- Medical co-pays.

What Is Coinsurance?

Coinsurance refers to the percentage you pay for most covered health services after you have met your medical deductible. Refer to your Benefit Summary for your percentage amounts as they can be different for each benefit.

When Do I Pay My Deductible and Coinsurance?

You may be asked to pay your deductible and coinsurance at the time of service or you will pay after we have processed your claim.

ALERT	
	You have a separate in-network and out-of-network deductible, coinsurance and out-of-pocket maximum. Your in-network benefits add up when you see a participating provider. Your out-of-network benefits add up when you see a non-participating provider. Your in-network benefits and out-of-network benefits add up separately.

What Is a Co-Pay?

Co-pay is the dollar amount you pay when you receive specific covered health services, treatments or supplies. It does not apply toward your medical deductible and out-of-pocket maximum. Refer to your Benefit Summary for health services that have specific co-pays.

When Do I Pay My Co-Pay?

You will be asked to pay your co-pay at the time of receiving services.

What Is an Out-of-Pocket Maximum?

The out-of-pocket maximum is the total amount of deductible and coinsurance you pay out of your pocket for covered health services during the year. Refer to your Benefit Summary for your specific out-of-pocket maximum. Each member covered by this plan has an out-of-pocket maximum. After you have reached this maximum, we pay 100% of our allowed amount for covered health services from participating providers for the remainder of the plan year.

What Is an Annual Dollar Limit?

An annual dollar limit is the total amount paid by us each year for you while covered under this Certificate of Coverage. Please refer to your Benefit Summary for your annual dollar limit.

Do I Have a Lifetime Dollar Limit?

No, you do not have a lifetime dollar limit. Essential health benefits provided within this Certificate of Coverage are not subject to a lifetime dollar limit. Essential health benefits include the items and services in the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care.

Finding a Health Care Provider

How Do I Find a Participating Provider?

A participating provider means a physician or licensed health care professional, hospital, facility, institution, agency or pharmacy that has signed a contract with us to provide health services to our members.

To access the most up-to-date information, review our online provider directory at **www.AveraHealthPlans.com.** You can also call our Service Center and speak to one of our service associates.

For members who live outside our service area for longer than 90 consecutive days, we contract with expanded regional and national networks so you can continue to receive in-network coverage. For more information, contact our Service Center.

When you require a health service or specialty not available in the Avera Health Plans network, you are encouraged to call our Service Center and ask for help with care coordination from our Care Management Department. Your out-of-network benefit allows you to seek another opinion or care from a non-participating provider. However, you will pay more for health services from a non-participating provider.

Why Should I Choose a Participating Provider?

When you receive covered health services from participating providers, you have advantages such as:

- You will pay a lower percentage of coinsurance for services after you pay your medical deductible.
- Participating providers accept our payment arrangements, which may result in savings for you.
- Participating providers file claims for you.
- Some services are covered only when you see a participating provider.
- We settle claims directly with participating providers.

Why Does Using a Non-Participating Provider Cost Me More?

When you see a non-participating provider:

- You will have to pay an out-of-network deductible and coinsurance which is separate from your in-network deductible and coinsurance.
- You will pay a higher percentage of coinsurance after you have met your out-of-network deductible.
- You will pay the difference between the billed charge and our allowed amount. This amount does not apply to your out-of-pocket maximum.

- All non-participating provider bills (hospitals and physicians) are subject to an allowed amount. This amount is established by using various methodologies.
- You may have to pay the full charge to the non-participating provider at the time of service and send the claim to us.

How Do I Compare Participating and Non-Participating Provider Payments?

The chart below shows how we pay benefits when we are your primary insurance. For these examples, assume you have met your medical deductible and you haven't reached your out-of-pocket maximum. Your coinsurance for health services from a participating provider is 20% and your coinsurance for non-participating providers is 40%.

	Provider's Charge	Our Allowed Amount	Provider Accepts Our Allowed Amount	We Pay	You Pay
Participating Provider	$1,000	$900	Yes	$720 ($900 x 80% = $720)	$180 ($900 x 20% = $180)
Non-Participating Provider	$1,000	$900	No	$540 ($900 x 60% = $540)	$460 ($1,000 - $540 = $460)

When to Call Before Receiving Medical Services

You will need to have your provider call us to precertify certain medical services. If your provider does not call, services will not be covered.

ALERT

Precertification does not guarantee benefits. Your benefits are subject to all conditions of this Certificate of Coverage.

What Is Precertification?

Precertification means the notification process when specific services, supplies and procedures for care and treatment are approved by us prior to being received. Precertification does not guarantee benefits. Your benefits are subject to all conditions of this Certificate of Coverage.

What Medical Services Require Precertification?

To review the most current list of services needing precertification, visit us online at **www.AveraHealthPlans.com**

What If I Want To Request In-Network Benefits For Health Services From a Non-Participating Provider?

You will need to call us to request in-network benefits for health services from a non-participating provider (except for emergency care).

What Is the Precertification Process?

- You or your provider needs to call us. The precertification telephone and fax numbers are on the back of your member ID card.
  - Your provider needs to call us if you need health services requiring precertification.
  - You need to call us if you are requesting in-network benefits for health services from a non-participating provider.
- We will review the information and when a decision has been made, you and your provider will receive a letter that states the decision.
  - NOTE: If the health services are approved, the letter will list the services that have been pre-certified (for example, office visit only or office visit and lab tests). Please read this letter carefully so you know what services have been pre-certified.
  - If your request for precertification is urgent meaning a delay could jeopardize your life, health or ability to regain maximum function or would cause severe pain that

could not be adequately managed without the requested care or treatment we will respond within 24 hours.

What is Predetermination of Services?

Predetermination of services means a review by our medical staff to determine if a service is medically necessary and consistent with our medical policies. Predeterminations are not required prior to receiving services, but are helpful in reducing the risk of coverage being denied based on our medical policies. Predetermination of services does not guarantee benefits. Your benefits are subject to all conditions of this Certificate of Coverage.

To request a predetermination of services, you or your provider will need to call Medical Management at 1 (888) 605-1331.

Some examples of services we suggest you request a predetermination for are:

- Panniculectomy
- Sclerotherapy
- Blepharoplasty
- Breast Reduction
- Botox
- Infertility Services
- Lumbar surgical procedures including same day surgery

What I Pay for Prescription Drugs

How Much Will I Pay for Prescription Drugs?

The amount you pay for your prescription depends on the drug's tier level and the benefit level chosen by your employer and shown on your Benefit Summary.

We classify drugs into four tiers:

Tier	Drugs	Your Cost
Tier 1	Preferred generic and select brand medications	Lowest
Tier 2	Preferred brand and non-preferred generic medications	Higher co-pay than Tier 1

Tier 3	Non-preferred brand medications	Higher co-pay than Tier 2
Tier 4	Specialty medications, brand and generic	Highest

If you choose to fill a brand-name drug when a generic equivalent is available, you will pay the co-pay plus the cost difference between the brand-name drug and the generic. This amount will not apply to your deductible or your out-of-pocket maximum.

Our list of preferred prescription drugs is referred to as a Drug Formulary. A Drug Formulary contains a wide range of generic and brand-name drugs that have been approved by the U.S. Food and Drug Administration (FDA). Your physician can use this list to choose medications for you while helping you save the most money.

Generic Drug – A drug that has the same active ingredients as its brand-name counterpart, and has been approved by the FDA as being interchangeable with the brand-name drug as approved by your provider.

Brand-Name Drug – A drug that is manufactured and marketed under a trademark or name by a specific drug manufacturer.

To find out which drugs are on our Drug Formulary, visit us at **www.AveraHealthPlans.com** or request a copy by contacting our Service Center.

What is Step Therapy?

Step therapy uses the most cost-effective and safest medication available for a specific medical condition. Step therapy programs require your provider to prescribe a step-one medication before a step-two medication. Visit our website to review a list of Step Therapy Programs.

How Does Step Therapy Work?

Your provider prescribes a step-one medication. Step-one medications are proven to be safe and effective. If the step-one medication is not effective or causes adverse effects, your provider may prescribe a step-two medication. Step-two medications may cost more or have an increased risk to you.

What is the Step Therapy Process?

- The pharmacist enters your prescription information into the claims system.
- If your medication is a step-one medication, the pharmacist will fill your prescription.
- If your medication is a step-two medication, the pharmacist will contact your provider.

  Your provider can:

- Prescribe a step-one medication or
- Call our pharmacy benefit manager to request a step therapy override. (This may take up to two business days to complete.)

If the override is approved, the pharmacy will fill your prescription for the appropriate co-pay.

If the override is denied, the provider will need to prescribe a step-one medication. If you and your provider decide not to go through the override process, your provider can prescribe a step-two medication and you will pay the full cost of the prescription.

FOR MORE INFORMATION

To find the most current list of drugs on our Drug Formulary, visit us at www.AveraHealthPlans.com or request a copy by contacting our Service Center.

When to Call Before Receiving Pharmacy Services

You need to have your provider or pharmacist call us for prior authorization of some pharmacy services. If you do not, services may not be covered.

What Is Prior Authorization?

Prior authorization means the notification process when specific prescription medications are approved by us prior to being received. Prior authorization does not guarantee benefits. Your benefits are subject to all conditions of this Certificate of Coverage.

What Drugs Require Prior Authorization?

To review the most current list of medications needing prior authorization, visit us online at **www.AveraHealthPlans.com** for:

- Drugs Requiring Prior Authorization or
- Drug Formulary – this is our list of preferred prescription drugs. The initials (PAR) show after the drug name on the Drug Formulary. PAR means "prior authorization required."

What Is the Prior Authorization Process?

To receive prior authorization:

- Ask your physician to obtain prior authorization before prescribing the medication or
- When you present your prescription at a participating pharmacy, the pharmacist will contact the pharmacy benefit manager listed on your member ID card.

Without prior authorization for specified drugs, you are responsible for paying the entire billed charge.

What are Specialty Medications?

Specialty medications treat chronic, complex conditions such as hepatitis C, multiple sclerosis, cancer and rheumatoid arthritis. These medications tend to be high cost and require special storage and handling. If you need a specialty medication, you will be limited to a 30-day supply.

Where Do I Obtain My Specialty Medication?

If you need a specialty medication, we have a network of specialty pharmacies available to you. Our specialty network offers convenience and choice for delivery of your medications. You can choose to have your specialty medications delivered to your home or another convenient location approved by us. Specialty medications can be picked up at:

- Avera McKennan Hospital & University Health Center pharmacies,
- Brown Clinic Pharmacy, Watertown, SD,
- Bon Homme Pharmacy, Tyndall, SD

For complete information about our specialty network, please call our Service Center at (605) 322-4545 or toll-free at 1 (888) 322-2115.

What Is Covered and Not Covered

Covered health services apply to your appropriate deductible, coinsurance or co-pay. See your Benefit Summary for a list of most common benefits and how much you pay for these services. See also the section General Exclusions for additional benefit exclusions.

For us to cover a service or supply, it must meet all of the following requirements:

- Follow our medical review and precertification requirements,
- Be listed below as covered, and
- Be medically necessary.

Medically Necessary means health services which have been determined by our medical director to be of value in the care of a specific member. To be medically necessary, a service must:

- Not be investigational, experimental or unproven,
- Be used to diagnose or treat a member's condition caused by disease, injury or congenital malformation,
- Be provided at the most appropriate site and at the most appropriate level of service for the member's medical condition,
- On an ongoing basis, have a reasonable probability of:
  - Correcting a significant congenital malformation or disfigurement caused by disease or injury,
  - Preventing significant disease or malformation,
  - Substantially improving a life-sustaining bodily function impaired by disease or injury.
- Not be provided solely to improve a member's condition beyond normal variations in individual development and aging including:
  - Comfort measures in the absence of disease or injury,
  - Improving physical appearance that is within normal individual variation.
- Not be for the sole convenience of the provider, member or member's family.

Abortion

Not Covered: Elective termination of pregnancy services performed only for the purpose of terminating a pregnancy.

Acupuncture and Other Alternative Treatments

Not Covered: Acupuncture, acupressure, biofeedback, massage therapy, naturopathy, homeopathy, holistic medicine or therapeutic touch.

Alcohol Dependency Treatment Services

Covered: Inpatient, outpatient and partial-day programs from a licensed or certified provider.

TIP

If you travel outside the U.S., consider getting special insurance for air ambulance services. If outside the U.S., we cover air ambulance only to the nearest facility (such as a hospital) that can provide the care you need.

Ambulance and Transportation Services

Covered: Medically necessary transportation by licensed professional ground ambulance, air ambulance or on a regularly scheduled flight on a commercial airline when transportation is:

- An emergency transfer to a hospital or between hospitals

or

- A planned transfer between hospitals or a planned transfer from a hospital to a skilled nursing facility, only when the transfer is arranged and approved by us.

Not Covered: Non-emergency travel.

Anesthesia Services

Covered.

Anesthesia and Hospital Services for Dental Care

Covered: General anesthesia and/or hospitalization for covered dental services for a member who is under age 5, is severely disabled or has a medical condition that puts such member at serious risk as determined by a licensed physician.

ALERT

The fact that a physician or other provider prescribes, orders, recommends or approves a service or supply does not make it medically necessary.

Autism

Not Covered.

B-12 Injections

Covered: Only for pernicious anemia.

Blood and Blood Products

Covered: The administration of blood and blood products. The purchase of blood and blood products if they are classified as drugs in the United States Pharmacopoeia.

Breast Pumps

Covered: cost for renting breastfeeding equipment.

Cancer Clinical Trials

Covered: Routine care which includes diagnostic or laboratory services and scans or treatments which would be covered even if you were not enrolled in the clinical trial.

Not Covered: Investigational, experimental, drugs, procedures or devices and any costs paid for by the clinical trial sponsor under the study guidelines.

Cardiac Rehabilitation Phases I and II

Covered: Cardiac Rehabilitation Phase I when in the hospital. Cardiac Rehabilitation Phase II is explained in your Benefit Summary.

Casts, Splints, Braces, Crutches and Dressings

Covered: Items are covered if received in a physician's office, emergency room or hospital.

Chelation Therapy

Covered: Only for acute arsenic, gold, mercury or lead poisoning.

Chemical Dependency Treatment Services

Covered: Inpatient, outpatient and partial-day programs for chemical dependency treatment from a licensed or certified provider.

Chemotherapy/Radiation Therapy

Covered.

Chiropractic Services

Covered: Precertification is required after a certain number of visits are met. Please see your Benefit Summary for further information.

Not Covered: Massage therapy.

TIP

Clinical Trials. Before signing up for a clinical trial, be sure to contact our Service Center to determine what services will be covered.

Contraceptives

Covered: All FDA contraceptive methods, sterilization procedures, and patient education and counseling.

Not Covered: Abortifacient drugs

Cosmetic Services

Not Covered: Cosmetic drugs, health services or surgery performed to:

- Improve physical appearance that is normal for individual development and aging,
- Improve physical appearance or change or restore bodily form when there is no functional impairment or when it is not medically necessary or
- Prevent or treat a mental or nervous disorder through a change in bodily form.

Counseling Services

Covered: Counseling for mental health illnesses.

Not Covered: Counseling services such as:

- Marriage counseling,
- Family counseling,
- Bereavement counseling,
- Pastoral counseling,
- Financial counseling,
- Legal counseling and
- Custodial care counseling.

Custodial Care

Not Covered: Custodial Care is care for personal needs and medical needs if a patient has reached the maximum level of physical or mental function and is not likely to make improvements. The patient may or may not require care from a licensed professional. Caregivers and family members can be trained to care for the patient. Custodial Care is also called maintenance care.

Custodial Care may include:

- Help with activities of daily living, such as walking, dressing, bathing, preparation of food or tube feedings and giving medications or treatments,
- Care for a patient who depends on medical equipment, such as ventilators and oxygen and
- Care for a patient that requires supervision because of a chronic condition such as Alzheimer's Disease.

Dental Services

Covered: Services required because of injury, accident or cancer that damages natural teeth (but not the replacement of lost teeth). Associated radiology services are included. "Injury" does not include injuries to natural teeth caused by biting or chewing. "Natural teeth" include teeth that are crowned, filled or have received dental restoration. A dental

See also Anesthesia and Hospital Services for Dental Care.

Not Covered: Dental services such as:

- Dental X-rays,
- Ridge augmentation,
- Implantology,
- Preventive vestivuloplasty and
- Impacted teeth removal.

Diabetes Education, Supplies and Equipment

Covered: Equipment, supplies and self-management training and education, including medical nutrition therapy, for treatment of members diagnosed with diabetes if prescribed by a physician or other licensed health care provider.

Diabetes Education

Diabetes self-management training and education is covered if:

- The service is provided by a physician, nurse, dietician, pharmacist or other licensed health care provider who satisfies the current certification requirements of the National Certification Board for Diabetes Educators.
- The training and education is based upon an approved diabetes program recognized by the American Diabetes Association or the South Dakota Department of Health.

Coverage of diabetes self-management training is limited to:

- Members who are newly diagnosed with diabetes or have received no prior diabetes education,
- Members who require a change in current treatment,
- Members who have another condition such as heart disease or renal failure or
- Members whose diabetes condition is unstable.

Under these circumstances, a maximum of two education programs per lifetime and up to eight follow-up visits per year will be covered. Coverage is limited to the closest available qualified education program that provides the necessary management training to accomplish the prescribed treatment.

Diabetes Supplies
Supplies such as blood glucose test strips, urine test strips, insulin, injection aids, lancets, lancet devices, syringes and all supplies for the pump prescribed, oral agents for controlling blood sugars, glucose agents, glucagon kits, insulin measurement and administration aids for the visually impaired (such as blood glucose monitors), and other medical devices for treatment of diabetes.

Diabetes Equipment
Equipment such as blood glucose monitors, one pair of orthopedic shoes, insulin pumps and insulin infusion devices. See also Durable Medical Equipment.

TIP

The following diabetes supplies are covered under your pharmacy benefit:

- Test strips
- Blood glucose monitors
- Lancets
- Syringes

You need to get these supplies at a pharmacy.

Not Covered: Food items and nonprescription drugs for medical nutrition therapy.

Durable Medical Equipment (DME)

Durable Medical Equipment is appropriate for home use for the purpose of improving bodily functions or preventing further deterioration of the medical condition caused by illness or injury.

Covered: Equipment that is:

- Prescribed by a physician,
- Medically necessary,
- Appropriate to treat your condition (as determined by us),
- Designed for long-term use and
- Designed and used for a specific therapeutic purpose in the treatment of a covered illness or injury.

Durable medical equipment includes items such as:

- Crutches, walkers, wheelchairs, nebulizers, hospital beds, C-PAP and Bi-PAP,
- Rental or purchase (as determined by us) of durable medical equipment (combined rental fees cannot exceed the full purchase price),
- New, used or refurbished equipment (as determined by us),
- Replacement and repairs when medically necessary and appropriate,
- Oxygen units (one stationary and one portable unit depending on medical necessity) and
- Continuous blood glucose monitors, insulin pumps and insulin infusion devices.

NOTE: Precertification is required for some items. Please see your Benefit Summary for further information.

Not Covered:

- Equipment for adapting your vehicles or home,
- Non-sealed batteries,
- Speech equipment,
- Replacement or repairs due to damage or loss and
- Convenience items.

FOR MORE INFORMATION

Please review the emergency medical condition in the definition section of this Certificate of Coverage.

Education Programs and Tutoring Services

Not Covered: Services such as family planning and cholesterol education programs.

Emergency Care Services

Covered: Emergency services are covered for diagnosis and treatment of an illness or injury. If you have an emergency, go directly to the nearest emergency facility or call 911.

Fertility/Infertility Services

Covered: Services necessary to rule out disease, injury or congenital malformation that may present as infertility.

Not Covered: Any services to treat infertility and fertility services such as:

- Enhancing fertility,
- Ovulation induction,
- Reversing sterilization procedures,
- Artificially inseminating,
- Artificially fertilizing an ovum and
- Transferring a zygote.

Foot Care

Covered: Routine foot care as part of corrective surgery or for diabetes and metabolic or peripheral vascular disease.

Not Covered: Foot care services such as:

- Cutting, removal or treatment of corns or calluses,
- Treatment of weak, strained or flat feet or
- Trimming or debridement of nails.

Genetic Testing

Covered: Genetic testing is covered when the test results will determine a course of treatment or care. Precertification is required.

Not Covered: Genetic testing that is used primarily for:

- Family planning or
- Informational purposes.

Hearing Services

Covered: Hearing examinations are covered if related to illness or injury.

Not Covered: Hearing aids and tinnitus maskers, including the examination, purchase, fitting and supplies.

Hemodialysis

Covered: Only for renal disease. Services include equipment, training and medical supplies required for effective home dialysis care.

Home Health Services

Covered: Home health services from a licensed or certified provider.
The following services are covered if ordered by a physician:

- Part-time or intermittent care by a registered nurse (RN) or licensed practical nurse/licensed vocational nurse (LPN/LVN),
- Part-time or intermittent home health aide services for direct patient care only if you are also receiving part-time or intermittent care by a registered nurse (RN) or licensed practical nurse/licensed vocational nurse (LPN/LVN) or
- Physical, occupational, speech, inhalation and intravenous therapies.

Please see your Benefit Summary for further information.

Not Covered: Custodial or maintenance care and respite care.

Hospice Services

Hospice care provides pain relief care and support services for the physical, emotional, social and economic needs of terminally ill patients and their families without intent to cure.

Covered: Hospice services from a licensed or certified provider if you have been diagnosed with a terminal disease with a life expectancy of 6 months or less. Hospice services include:

- Admission to a hospice facility, hospital or skilled nursing facility for room and board, supplies and services for pain management and other acute/chronic symptom management,
- Part-time or intermittent nursing care by a registered nurse (RN), licensed practical nurse/licensed vocational nurse (LPN/LVN) or home health aide for patient care up to 8 hours per day,
- Social services under a provider's order and
- Psychological and dietary counseling.

During hospice care, you are no longer entitled to any additional benefits that are specific to the terminal disease.

Please see your Benefit Summary for further information.

Hospital Services

Covered: Inpatient and outpatient hospital services:

- Room and board for semi-private room,
- Critical care services,
- Use of the operating room and related facilities,
- Nursing services including special duty nursing if approved by us,
- Other services, supplies, biologicals, drugs and medicines prescribed or ordered by a physician and administered during hospitalization and
- Inpatient rehabilitation services.

Precertification is required for inpatient services.

Not Covered:

- Drugs provided by a hospital that are not used while in a hospital and
- Personal hygiene and convenience items such as toothbrush, toothpaste, slippers or Kleenex®.

Hypnotism, Hypnotic Anesthesia and Sleep Therapy

Not Covered.

Inhalation Therapy

Covered: Breathing or respiratory treatments to restore or improve breathing.

Laboratory and X-ray Services

Covered.

Massage Therapy

Not Covered.

Maternity Services

Covered: Routine prenatal and postnatal care and delivery. Complications resulting from pregnancy will be treated as any other illness or injury. Maternity services include:

- A minimum of 48 hours of inpatient care in a licensed health care facility, for both mother and newborn child, following a vaginal delivery and
- A minimum of 96 hours of inpatient care in a licensed health care facility, for both mother and newborn child, following a cesarean section.

Upon the recommendation of the mother's physician, the mother and newborn's hospital stay may be shorter if they meet medical criteria established by the American College of Obstetrics and Gynecology. When their hospital stay is shorter, coverage includes a follow-up postpartum home visit within 48 hours of discharge.

Maternity services are covered as a result of surrogate pregnancy.

Elective termination of pregnancy is covered only when medically necessary to save the life of the mother. Medical complications arising from an elective termination of pregnancy shall be considered covered benefits.

Not Covered: Elective termination of pregnancy services performed solely for the purpose of terminating a pregnancy.

Medical Supplies

Medical supplies are disposable and needed for the treatment of an illness or injury.

Covered: Supplies such as:

- Colostomy supplies,
- Catheters and
- Infusion sets for insulin pumps.

Not Covered:

- Any medical supplies that can be purchased without a prescription
- Diabetes supplies and blood glucose monitors (these items are covered under Prescription Drugs and Supplies).

Mental Health Services

Covered: The diagnosis and treatment from a licensed or certified provider for the following biologically based mental illnesses as classified in the current revision of the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*:

- Biologically based mental illness,
- Schizophrenia and other psychotic disorders,
- Bipolar disorder,
- Major depression and
- Obsessive-compulsive disorder.

Also covered:

- Anorexia
- Bulimia

Not Covered: Mental health services such as:

- Learning disabilities,
- Behavioral problems, modifications, therapy and training,
- Cognitive impairment,
- Developmental care,
- Developmental delays,
- Inpatient hospitalization for co-dependency,
- Bio-feedback,
- Inpatient hospitalization for environmental change,
- Marital, family, educational, vocational, recreational or other counseling services,
- Milieu therapy,
- Sensitivity training,
- Eating disorders (unless described as **Also covered** above),
- Conduct disorders and
- Autism.

Newborn Care

Covered: An enrolled newborn from birth, including care and treatment for illness and injury.

Nursing Home and Long-Term Care

Not Covered.

See also Skilled Nursing Services.

Nutritional Supplements

Covered: 100% amino acid-based elemental formulas for the following conditions when diagnosed and documented by a pediatric gastroenterologist or pediatric endocrinologist:

- IGE mediated allergies to food proteins,
- Food protein induced enterocolitis syndrome,

- Eosinophilic esophagitis (EE),
- Eosinophilic gastroenteritis (EG) and
- Eosinophilic colitis.

Not Covered: Food supplements, nutrients, infant and adult formulas unless described as **Covered** above and vitamins except for A, D, E, K and prenatal.

Orthognathic Surgery

Orthognathic surgery is surgery on the upper or lower jaw.

Covered: Only for the treatment of cancer or because of trauma.

Orthotic and Orthopedic Devices

Orthotic and orthopedic devices are designed to support, align, prevent or correct deformities. These devices can also improve the function of moveable parts of your body.

Covered.

Not Covered:

- Orthopedic shoes,
- Foot orthotics such as shoe inserts,
- Sports-related or performance-enhancing devices,
- Duplicate or replacement of lost devices,
- Arch supports, wedges, heel cups and heel lifts and
- Examinations for the prescription or fitting of orthotic services and supplies.

Over-the-Counter Supplies

Not Covered.

Phenylketonuria (PKU)

Covered: Testing, diagnosis and treatment including dietary management, formulas, care management, intake and screening, assessment, comprehensive care planning and service referral.

Physician Services

Covered: Services such as:

- Office visits,
- Inpatient visits,
- Injectible medication and
- Surgical care.

Prescription Drugs

Prescription drugs are medications, products or devices that:

- Have been approved by the U.S. Food and Drug Administration,

- Are available only by a prescription, according to state and federal law,
- Are packaged for self-administration, including self-injectables or administered by a non-skilled caregiver (for example, insulin) and
- Include compounded medications that contain at least one ingredient, available only by prescription.

Covered: Prescription drugs that are:

- Prescribed by a licensed provider,
- Purchased at a participating pharmacy, except in case of medical emergency or
- Dispensed in a 90-day supply through mail order or through a participating pharmacy that has agreed to dispense a 90-day supply.

ALERT

Prior authorization and quantity limits may apply to specific prescription drugs.

Not Covered:

- Drugs that are received without charge under a federal, state or local program,
- Drugs used for cosmetic purposes including baldness,
- Drugs provided by a hospital that are not used while in a hospital,
- Prescription refills that are more than one year old,
- Prescription drugs for smoking cessation treatment,
- Prescription drugs in an amount that is over the day's supply or quantity limit,
- Over-the-Counter drugs that do not require a prescription unless the over-the counter drug is part of a program we offer,
- Prescription drug products that we have determined are therapeutically the same as an over-the-counter drug,
- Investigational, experimental or unproven drugs or drug usage,
- Prescription drugs considered homeopathic, a dietary supplement or nutraceutical in nature including combinations with a prescription drug,
- Drugs used to treat infertility or to enhance fertility,
- Drugs used for weight-loss,
- Injectable drugs that cannot be self-administered,
- Serums, toxoids or vaccines except flu, pneumococcal and shingles,
- Vitamins, except for vitamins A, D, E, K and prenatal, or
- Fluoride, except pediatric formulations.

TIP	
	Our Drug Formulary is a list of prescription drugs that contains generic and brand-name drugs approved by the U.S. Food and Drug Administration (FDA). Your physician can use this list to choose medication for you while helping you save the most money. You can check our website: www.AveraHealthPlans.com or call our Service Center for the most recent Drug Formulary listing.

Preventive Care Services

Covered: Services such as:

- Well child visit,
- Annual physical exam,
- Annual well woman,
- Routine immunizations,
- Mammogram,
- Prostate cancer screening (PSA test),
- Colorectal screening,
- Lipid screening,
- Glucose screening or
- Osteoporosis testing.

TIP

Routine Immunizations are recommended vaccines as listed on the United States Centers for Disease Control and Prevention (CDC) Child, Adolescent and Adult Immunization schedules. These are recommended for all persons within the age group.

Please visit our website at www.AveraHealthPlans.com for a complete list of covered preventive care and screening services as recommended by the United States Preventive Services Task Force, the Health Resources and Services Administration and the Centers for Disease Control.

Please see your Benefit Summary for further information.

Not Covered: Physical, psychological and psychiatric examinations and testing that are done for non-medical reasons such as:

- School physicals,
- Sports physicals,
- Pre-employment and employment physicals,
- Immunizations and physical exams required by another person or organization, or received for travel,
- Insurance physicals,
- Government licensing physicals (such as physicals and eye exams for driver licenses) and
- Camp physicals.

Prosthetic Devices

Prosthetic devices are:

- External devices used for artificial substitutes to replace a missing natural part of the body or
- Other devices to aid or restore the performance of a natural function.

Covered: Precertification is required for any prosthetic device over $25,000.

Not Covered:

- Sports-related or performance-enhancing devices,
- Myoelectric (computerized) devices,
- Dental devices,
- Speech devices and
- Duplicate or replacement if the device is lost.

Reconstructive Breast Surgery

Covered:

- Reconstructive services for members who had a mastectomy that was or would have been covered by us,
- Surgery and reconstruction of the other breast to make it similar in size and
- Prostheses and treatment for physical complications at all stages of the mastectomy including lymphedemas.

Not Covered:

- Replacement of a breast implant if the implant was used for cosmetic reasons.

Reconstructive Services

Covered: Any service or procedure performed primarily to improve bodily function:

- To correct a significant congenital malformation or disfigurement caused by disease or injury or
- To correct malformation and disfigurement that is outside of normal development and aging.

Not Covered: Dental Services and Gender Identity Disorder

Self-Help Programs

Not Covered:

- Education programs and tutoring services,
- Health club or gym memberships,
- Physical fitness programs or
- Weight-loss clubs or clinics.

Sexual Dysfunction Treatment

Covered: If related to disease, injury or congenital malformation.

Skilled Nursing Facility Services

Covered:

- Skilled nursing care provided in an inpatient skilled nursing unit or in a skilled nursing facility,
- Room and board in a skilled nursing facility and
- Special diets in a skilled nursing facility if specifically ordered.

Please see your Benefit Summary for further information.

Not Covered:

Skilled nursing and nursing home facility services and long-term care or confinement:

- When treatment is primarily custodial, convalescent, intermediate level or domiciliary care, rest cures or care or

- When primary use of the facility is to assist in activities of daily living.

Smoking Cessation Treatment
Not Covered.

Sterilization Services
Covered:

Not Covered: Reversing sterilization procedures

Surgical Center Services (Ambulatory Surgical Center)
Covered: Services furnished in connection with a surgical procedure performed in a licensed or certified ambulatory surgical center.

Surgical Services
Covered.

TMJ (Temporomandibular Joint Disorder) and Craniomandibular Disorder
Not Covered: Treatment or supplies for jaw disorders, mouth conditions due to periodontal or periapical disease, or the teeth, their surrounding tissue or structure, the alveolar process or the gingival tissue.

Therapy
Covered:

- Physical therapy
- Occupational therapy
- Speech therapy

These outpatient rehabilitation therapies improve physical functioning and provide significant improvement within two months.

Precertification is required after a certain number of visits are met. Please see your Benefit Summary for further information.

Not Covered: Specialized rehabilitation programs (also referred to as work hardening programs) that are set up to be like your workplace activities and surroundings in a monitored environment.

Transplant Services
A transplant is the replacement of a body organ, including bone marrow and cornea, by another human non-mechanical body organ because of disease or injury.

Covered: Medically necessary transplant services at a single transplant center approved by us. Services include evaluation, donor search, transplant, follow-up care and immunosuppressive drugs (subject to limitations listed below).

- Precertification is required for all evaluations and transplant services. It is your responsibility to obtain precertification. Failure to obtain precertification may result in no benefits being payable.
- All transplant-related services must be provided by a facility approved by us.
- Medical expenses are covered for the testing of the donor, surgical extraction, storage and transportation costs incurred that are directly related to the donation of the organ used in an organ transplant procedure.

Not Covered:

- Expenses related to transplants of animal organs,
- Artificial organs,
- Expenses incurred by you as a donor, unless the recipient is also a member and these services are not covered under another group health plan or coverage arrangement and
- Expenses for transplants at a non-participating facility or a facility not approved by us.

Travel

Covered: Emergency medical services if you are traveling outside our service area.

Not Covered: Items such as meals, lodging, airfare and other miscellaneous expenses.

Vision Services

Covered:

- For Aphakia patients or after cataract surgery--prescribing, fitting and the purchase of eyeglasses or contact lenses or
- For eye disease or injury – soft contact lenses or scleral shells.

Not Covered:

- Eye surgery to alter the refractive character of the cornea, such as radial keratotomy, myopic keratomileusis or LASIK surgery,
- Eyeglasses or contact lenses including the examination, purchase and fitting or
- Any other procedure or service to correct vision or refractive errors, such as vision therapy.

Weight-Reduction

Covered: Gastric banding or Roux-en-Y gastric bypass surgery for weight-reduction

- You must be a member on the plan for 1 year and meet medically necessary criteria.
- You must be at least 18 years of age or older,
- Precertification is required. It is your responsibility to obtain precertification. Failure to obtain precertification may result in no benefits being payable.
- Your weight-reduction surgery must be provided at Avera McKennan Hospital & University Health Center located in Sioux Falls, S.D. or Avera Queen of Peace Hospital located in Mitchell, S.D.

Not Covered:

- Reversals or revisions of gastric banding or gastric bypass that do not meet medically necessary criteria.
- Dietary programs and treatment for reducing or controlling weight including any service, program or procedure designed to promote weight-loss,
- Health services related to surgery for removal of excess fat in any area of the body or
- Removal of excess skin or fat following weight-loss or pregnancy.

Please see your Benefit Summary for further information.

Wigs or Cranial Prostheses

Not Covered.

General Exclusions

This section describes health services that are excluded from coverage. We are not responsible for payment, and the services don't apply toward your benefits.

1. All health care services which are not medically necessary.

2. All charges related to a non-covered health service, even if the service was medically necessary.

3. Equipment not primarily intended to improve a medical condition or injury such as:
   - Air conditioners or air purifying systems,
   - Humidifiers,
   - Exercise equipment or
   - Hot tubs or whirlpools.

4. Expenses and supplies for activities of daily living such as household supplies and personal hygiene items and convenience items:
   - Meal delivery programs,
   - Housekeeping services,
   - Toothpaste,
   - Slippers or
   - Kleenex®.

5. Expenses or charges for:
   - Missed appointments,
   - Completion of forms,
   - Medical information,
   - The convenience or comfort of the member, the member's family, caretaker, physician or other medical provider,
   - Telephone calls to and from a physician, hospital or other medical provider,
   - Excise and sales taxes and
   - Translation services.

6. Expenses that are more than our allowed amount for health services from a non-participating provider.

7. Health care services:
   - That any other governmental body or agency is responsible for payment of benefits (except for Medicaid), unless we are required by law to provide primary coverage,
   - Provided before your effective date or after your termination date of coverage, unless provisions have been made to extend coverage,

- For conditions that under the law of this state must be provided in a governmental institution,
- Performed beyond the scope of practice authorized by law for the type of provider performing them,
- Performed by any provider who is a member of your immediate family by blood, marriage or adoption. This exclusion does not apply when the immediate family member is the only participating provider in the area.
- For injury or disease due to voluntary participation in a riot,
- For an illness or injury received while in the act of a felony and
- Ordered by a court or other governmental administrative or regulatory body or as a condition of parole or probation.

8. Investigational, experimental or unproven drugs or drug usage, if not recognized by the United States Food and Drug Administration.

9. Investigational, experimental and unproven medical services or technologies that have not yet met our standards for safety and effectiveness.

10. Medical or non-medical services provided by you or a caregiver including custodial and maintenance care.

11. Military service related injuries or illnesses. Treatment for any injury or illness received while you are on active duty, unless applicable law requires us to provide primary coverage.

12. Physical, psychological and psychiatric examinations and tests that are done for non-medical reasons such as:
    - School physicals,
    - Sports physicals,
    - Pre-employment and employment physicals,
    - Immunizations and physical exams required by another person or organization, or received for travel,
    - Insurance physicals,
    - Government licensing physicals (such as physicals and eye exams for driver licenses) and
    - Camp physicals.

13. Services that you are not legally or, as customarily practiced, required to pay in the absence of a group health plan or other coverage arrangement.

14. Treatment of any injury or illness that results from an act of declared or undeclared war or armed aggression.

15. Work-related injury or illness for which benefits are paid by a workers' compensation policy or similar law.

Pre-Existing Conditions

The Health Insurance Portability and Accountability Act (HIPAA) regulations require us to provide you with the following information regarding your employer's health plan. It is important that you read and understand this information.

If you have a medical condition before coming to the plan, you may need to wait a period of time before we will provide coverage for that condition. Treatment for pre-existing conditions may be denied for a period of 12 months, or 18 months for late members, following the effective date of coverage with us, or the first day of a waiting period if one applies. This period of time is called the pre-existing condition waiting period. (A late member is an individual who enrolls with us at a time other than the earliest date on which coverage can be effective or special enrollment dates.)

Pre-existing condition exclusions apply only to conditions for which medical advice, diagnosis, care or treatment (including drugs) was recommended or received during the six months immediately preceding your effective date of coverage with us or the first day of a waiting period if one applies.

Pre-existing condition exclusions do not apply to members under the age of 19.

Does the Pre-Existing Condition Waiting Period Apply to All Health Services?

No. This waiting period does not apply to pregnancy.

Does the Waiting Period Need to Be for 12 Months?

No. If you had prior creditable health insurance coverage, you can reduce the length of the pre-existing condition waiting period by the number of days of your prior health insurance coverage, as long as you have not been without health insurance coverage for 63 consecutive days or more.

> **For example**, if you have 4 months of health insurance coverage prior to your effective date with us, you will receive a credit for those 4 months (12 months - 4 months = 8 months). Your waiting period will be 8 months.

ALERT

Send us a copy of your Certificate of Creditable Coverage from your previous health insurance company to have your pre-existing condition waiting period reduced or removed.

How Do I Provide Proof of Prior Creditable Health Insurance Coverage?

In order for us to verify your prior health insurance coverage, we will need a copy of your Certificate of Creditable Coverage**.**

- A Certificate of Creditable Coverage is a letter or document from your previous health insurance company that shows the beginning and ending dates of your health insurance

coverage with them. If you had coverage with more than one health insurance company in the last 12 months, you must send a copy of the Certificate from each company.

- If you don't have a copy of your Certificate of Creditable Coverage, please contact your previous health insurance company to get one.
- Send a copy of the Certificate to us at the following address or you may fax it to us at (605) 322-4689. Please include your member ID number and group ID number on the Certificate.

Avera Health Plans
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

- After we receive the Certificate of Creditable Coverage, any prior creditable coverage will be applied toward your pre-existing condition waiting period, as long as you have not been without health insurance for 63 consecutive days or more.
- If your waiting period is not met, we will send you a written notice. It will include the length of time remaining on your waiting period. If your waiting period has been met, we will not send you a notice.

When I Have a Work-Related Injury

State law requires that you notify your employer of a work-related injury. We will not cover medical expenses for this injury, because these expenses are covered under your employer's workers' compensation insurance program.

If you agree to a settlement related to a work injury, giving up your right to have past or future medical benefits paid by your employer's workers' compensation insurance carrier, we will not cover past or future medical expenses that are related to that work injury and settlement. In addition, if you are covered by a workers' compensation program which limits benefits to certain providers and the providers you have chosen are not approved by your employer's workers' compensation program; we will not cover any medical expenses associated with such treatment.

If your workers' compensation program denies that you have a work-related injury, we will pay for your medical expenses until the dispute is resolved. Your health care services will be paid as described in this book.

When I Have Other Medical Coverage

What Is Coordination of Benefits?

It is common for family members to be covered by more than one health care plan. This happens, for example, when a husband and wife both work and choose to have family coverage through both employers.

When you are covered by more than one health plan, state law permits the health plans to follow a process called coordination of benefits. When you have a claim, coordination of benefits will determine how much each health plan should pay. The plan that pays first is the primary plan and the plan that pays second is the secondary plan. The goal is to make sure that the combined payments of all plans don't add up to more than your covered health care expenses.

This section describes some of the most commonly asked questions. If you still have questions, please contact our Service Center.

TIP

If you have other health coverage, it is important that you let us and all of your providers know including pharmacies for prescription drugs. Otherwise, the payment of your claims may be delayed or incorrect.

How Does Coordination of Benefits Work?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the primary or secondary plan.

- When you have a claim, the primary plan always pays first, as if the secondary plan did not exist. The secondary plan may consider the benefits paid by the primary plan to determine payment.
- Any plan that does not contain your state's coordination of benefits rules will always be primary.

Make sure all of your providers, including pharmacies for prescription drugs, know that you are covered by more than one plan. Some providers may send claims to your secondary plan, but some do not. In this case, you must send us the provider's claim and the Explanation of Benefits from the other plan so we can calculate the correct payment.

TIP

We follow South Dakota Coordination of Benefits Rules.

Do We Coordinate Benefits With All Plans?

No, we don't coordinate benefits with all plans. We coordinate benefits with plans that are:

- Group or individual insurance contracts and subscriber contracts,
- Group or group-type insurance contracts that are self-insured by the employer,
- Group-type contracts,
- Medical care components of long-term care contracts such as skilled nursing care,
- Medical coverage in automobile no-fault and traditional automobile fault-type contracts and
- Medicare and other government benefits, as permitted by law, except for medical assistance. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

We don't coordinate benefits with plans that are:

- Hospital indemnity coverage benefits or other fixed indemnity coverage,
- Accident-only coverage,
- Specified disease or specified accident coverage,
- Limited benefit health coverage,
- School accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or on a to-and-from-school basis,
- Medicare supplement policies,
- A state plan under the medical assistance program,
- A governmental plan, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan or
- Benefits provided in long-term care insurance policies for non-medical services including personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.

Each contract for coverage, whether or not it is a plan that we coordinate with, is a separate plan. If a plan has two parts and coordination of benefit rules apply only to one of the two, each of the parts is treated as a separate plan.

FOR MORE INFORMATION 	This is only an outline of the most common coordination of benefits situations. If your situation is not described in Which Plan Pays First?, please call our Service Center to assist you in determining who pays first.

Which Plan Pays First?

When we coordinate benefits with other plans, the following rules determine which plan pays first.

What If I Am Covered Under More Than One Insurance Plan?

- A plan that does not contain a coordination of benefits provision always pays first. (There is one exception: coverage that is obtained through membership in a group that supplements part of a basic package of benefits may provide that the supplementary coverage will be in addition to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are in addition to base-plan hospital and surgical benefits and insurance type coverages that are written in connection with a closed-panel plan to provide out-of-network benefits.)

- If you are a covered subscriber on one plan and a covered dependent on another plan, the plan that covers you as a subscriber is primary.

- If you are covered as a subscriber on two plans, the following rules apply:

    - **Active or Inactive Employee**. The plan that has covered you as an active employee pays before a plan that covers you as a retired or laid-off employee.
    - **COBRA**. The plan covering you as an employee, subscriber or retiree will pay before COBRA or a state continuation plan.
    - **Medicare**. If you have Medicare coverage, please see the section, How Does Medicare Coordination of Benefits Work?
    - **Longer or Shorter Length of Coverage**. The plan that has covered you as a subscriber the longest pays first.

ALERT

You must give us any facts we need to apply these coordination of benefit rules and determine the correct payment.

If the rules above don't determine who pays first, then each plan covers half of the allowed expenses. We will not pay more than we would have paid if we were the primary plan.

What If My Dependent Children Are Covered Under More Than One Insurance Plan?

- If a dependent child has coverage through his or her employment, the child's coverage pays before the parent's.

- We are always primary over Medicaid programs that cover children.

- Dependent children whose parents are married or are not separated follow the birthday rule.

- The plan of the parent whose birth month and day is earlier in the year pays first (for example, the plan of a parent born April 14 is primary over the plan of a parent born August

21). This rule looks only at the month and day, not the year. If both parents have the same birthday, the plan that covered either of the parents longer pays first.

- If the terms of a court order state that one of the parents is responsible for a child's health care expenses or health care coverage, then that plan pays first.

  Note: If the court order states that both parents are responsible for the child's health coverage and expenses or the court orders joint custody without specifying that one parent is responsible for the child's health coverage and expenses, then the birthday rule is used to determine which parent's plan pays first.

- Dependent children whose parents are not married, are separated (whether or not they have been married) or divorced parents and there is no court order that specifies which parent is responsible for providing health insurance coverage, the order of payment is:

  a. The plan of the custodial parent,
  b. The plan of the custodial parent's spouse,
  c. The plan of the non-custodial parent, then
  d. The plan of the non-custodial parent's spouse.

How Does Medicare Coordination of Benefits Work?

The table below explains how Medicare coordination of benefits works when you are an employee, retiree or COBRA participant and qualify for Medicare because of age, disability or end-stage renal disease.

How You Qualified for Medicare	Your Status	Employer Group Size	The Plan That Pays First
65+ years of age	Employee/Spouse	Less than 20 employees	Medicare
65+ years of age	Employee/Spouse	20+ employees	Employer
65+ years of age	Retiree/Spouse	Any size	Medicare
65+ years of age	COBRA Participant/Spouse	Any size	Medicare
Disabled	Employee/Spouse	Less than 100 employees	Medicare
Disabled	Employee/Spouse	100+ employees	Employer
Disabled	Retiree/Spouse	Any size	Medicare
Disabled	COBRA Participant/Spouse	Any size	Medicare
End-stage renal disease – less than 30 months	Employee/Spouse	Any size	Employer
End-stage renal disease – more than 30 months	Employee/Spouse	Any size	Medicare
End-stage renal disease – less than 30 months	Retiree/Spouse	Any size	Employer
End-stage renal disease – more than 30 months	Retiree/Spouse	Any size	Medicare
End-stage renal disease – less than 30 months	COBRA Participant/Spouse	Any size	Employer
End-stage renal disease – more than 30 months	COBRA Participant/Spouse	Any size	Medicare

Do I Need to Authorize the Release of Information?

No. Your authorization is not needed for us to obtain or release the necessary information. Each person claiming benefits under this plan must give us any facts we need to apply these coordination of benefits rules and to determine the correct benefits payable. We may get the facts we need from or release necessary facts to other organizations or persons for the purpose of applying these rules.

What Happens If the Other Plan Pays When We Are Responsible?

If another plan pays for a health service that we should have paid for, we will pay the provider or, if required by law, pay the other plan. The amount paid will be treated as though it was a benefit under our plan. We do not need to pay that amount to the provider of service.

What Happens If There Is an Overpayment?

If we pay more than we are responsible for, we may recover the overpayment from the person or organization that we paid in accordance with the laws of the state of South Dakota.

Filing a Claim

How Do I File a Claim for Medical Services?

When you go to a participating provider, the provider will file claims for you. So even if you get a bill from a participating provider, you don't need to send us a claim. If you have a question about whether your provider's office has filed your claim, check online at **www.AveraHealthPlans.com** and click the Member Login or call our Service Center.

If you receive health services from a non-participating provider, you will need to ask if they will file a claim for you.

How Do I File a Claim?

To file a claim, you need a standard claim form from your provider that describes the health services you received and the charges:

- Individual providers use claim form CMS 1500.
- Hospitals/facilities use claim form UB-04.

If your provider uses a non-standard claim form, the following information must appear on the provider's itemized bill for us to consider the claim for payment:

FOR MORE INFORMATION

Visit our website at www.AveraHealthPlans.com and click the Member Login to view your claims history and status.

- Patient's name and the Avera Health Plans member ID number,
- Diagnosis codes and service codes specific to the patient's injury or illness,
- Date and place of service and
- Provider's name, credentials (such as MD), address, phone number and tax ID number.

Please note that if we have to request additional information, this may delay the processing of your claim. We will send payment on your claim to the provider.

Make copies of your documents. It is a good idea to keep a copy (or keep the original and send us a copy) of any documents. Mail the claim form or itemized bill to:

Avera Health Plans
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

How Long Does It Take to Process a Claim?

We process most claims within 30 days. However, there may be delays in paying your claim for a variety of reasons such as:

- The information on the claim form is incomplete,
- We don't have up-to-date information on other insurance you or family members may have or
- We need more information from your providers.

How Long Do I Have to File a Claim?

You must file claims from a non-participating provider within 12 months of the date you received health care services. We will not pay claims filed more than 12 months after the date of service.

TIP

You must file prescription drug claims within 12 months of purchase.

What Happens If There Is an Overpayment?

If we pay more than we are responsible for, we may recover the overpayment from the person or organization that we paid in accordance with the laws of the state of South Dakota.

Complaint Procedures

The state of South Dakota requires us to provide you with the following complaint procedures. We encourage you to contact our Service Center with any concerns you may have. If you are not satisfied with a decision of ours that affects your coverage, you may submit a written complaint to us.

Once your complaint is filed, there are two levels of review:
1. First-level review (also referred to as standard internal review)
2. Second-level review (also referred to as an external review)

When Can I Submit a Complaint?

You or the person you authorize in writing to represent you (your authorized representative) may request a first-level review by submitting a written complaint or by completing a complaint form. You must submit the complaint within 180 days after the date you were notified of the action that is causing the complaint. (For example, if the date of service was January 1 but you didn't receive notice that the claim was denied until March 1, you would have 180 days from March 1 to submit your complaint.)

FOR MORE INFORMATION

If you would like assistance in filing a complaint and understanding the time frames and options, please contact our Service Center.

How Do I Submit A Complaint?

Complaint forms are available from our Service Center or on our website at www.AveraHealthPlans.com. You may send the complaint form or written request to:

Attn: Complaint and Appeals Coordinator
Avera Health Plans
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

What If I Have a Complaint That Is Urgent?

If you have an urgent complaint, you can request to have your review expedited. This type of review may be needed when:

- A delay could jeopardize your life, health or ability to regain maximum function or
- A provider who knows your condition tells us that a delay would cause severe pain that could not be adequately managed without the care or treatment you are requesting.

The time frame for us to respond to an urgent complaint is 72 hours. Your provider must call Medical Management at 1 (888) 605-1331 to

TIP

Please have your provider contact Medical Management to request an expedited complaint review. We have 72 hours to respond to an expedited complaint.

request an expedited complaint review. The phone number is also listed on the back of your member ID card. You do not need to submit your urgent complaint in writing. We will notify you and your provider by phone or fax of our decision. You will also receive written notification of our decision. The notification will be the same as the notifications for other complaints.

If the urgent complaint is concurrent, meaning you are receiving services at this time, you will not be responsible for charges related to the complaint from the time you submit the complaint until a decision has been made.

What Happens After I Submit the Complaint?

When we receive your complaint, we will send you or your authorized representative a letter within three working days to let you know we received your request. We will also tell you about the review process and how to contact our complaint and appeals coordinator. You have the right to submit documents, written comments, records or other information related to the complaint for consideration during the review. If requested, you will be provided, free of charge, copies of all relevant documentation that is not confidential or privileged used to make the initial decision.

Who Reviews the Complaint?

Your first-level complaint review will be handled by someone not previously involved with the initial decision. The review will take into account all relevant documents and information submitted, even if the information was reviewed in the initial decision. If necessary, your complaint will be reviewed by a physician of the appropriate specialty who understands the complaint process, whose scope of practice includes the services or treatment being reviewed and who was not involved in the initial decision.

How Will I Be Notified of the Decision?

We will notify you or your authorized representative of the decision in writing. The decision will include:

- The titles and qualifying credentials of the person or persons participating in the process,
- A statement summarizing your complaint,
- The reviewer's decision and the reason for the decision,
- The evidence or documentation source used to make the decision,
- Your right to request a second-level review (also known as an external review) if you are not satisfied with the decision. We will include information on the second-level external review complaint review process which is handled by the Division of Insurance,
- Your right to contact the Division of Insurance. The letter includes the address and toll-free telephone number and
- A reference to the specific plan provision on which the decision was made,
- A description of any additional material or information necessary to complete the request and an explanation as to why the information is necessary,
- If the decision was made relying on an internal rule or guideline, a copy of the internal rule or guideline will be provided to you free of charge,

- An explanation of the scientific or clinical judgment for making the decision, applying the terms of the health plan to your medical circumstances, if the decision was based on medical necessity or investigational and experimental grounds and
- A statement indicating your right to bring a civil action in a court of competent jurisdiction.

What If I Am Not Satisfied With First-Level Complaint Review Decision?

If you are not satisfied with the first-level complaint review decision, you have the right to request a second-level external review through the Division of Insurance.

An external review means an organization not connected with us reviews your complaint and makes a decision.

You or your authorized representative may request an external review by contacting us or the South Dakota Division of Insurance. If the South Dakota Division of Insurance approves your request, they will assign an Independent Review Organization.

How Do I File A Second-Level External Review Complaint?

In order to be eligible, you must file the complaint within four months (120 days) of the final decision. The cost is $25 and will be refunded to you if the Independent Review Organization's decision is in your favor or if your request is not eligible for external review

A second-level external review process can take up to 45 days for processing. When filing your request for a second-level external review, you will need to send in the following to the address listed below:

- A completed External Review Request form. This form can be found at www.AveraHealthPlans.com.
- A $25 application fee payable to S.D. Division of Insurance (check or money order).
- Photocopy of insurance identification card.
- A copy of the letter from us stating our decision is final and all internal review procedures have been exhausted or that we waived the requirements to exhaust all internal review procedures.
- A copy of your certificate of coverage or insurance policy benefit booklet, which lists the benefits under your health benefit plan.

South Dakota Division of Insurance
Attn: External Review
445 E. Capitol Ave.
Pierre, SD 57501

How Will I Be Notified of the Second-Level External Review Decision?

The Independent Review Organization will notify you or your authorized representative, us and the Division of Insurance of the decision. The written notification will include:

- The qualifying credentials of the person or persons participating in the process,

- A statement summarizing your complaint,
- The date the independent review organization received the assignment from the director to conduct the external review,
- The date the external review was conducted, the date and reviewers' decision along with the reason for the decision,
- The evidence or documentation source used to make the decision,
- A reference to the specific plan provision on which the decision was made,
- A description of any additional material or information necessary to complete the request and an explanation as to why the information is necessary,
- If the decision was made relying on an internal rule or guideline, a copy of the internal rule or guideline will be provided to you, free of charge,
- An explanation of the scientific or clinical judgment for making the decision, applying the terms of the health plan to your medical circumstances, if the decision was based on medical necessity or investigational and experimental grounds and
- A statement indicating your right to bring a civil action in a court of competent jurisdiction.

What If I Want To Know More About the External Review Process?

If you want to know more, please call our Service Center for additional information about the external review process. You may also contact the South Dakota Division of Insurance for assistance.

When Will I Be Notified of the Complaint Review Decisions?

Type of Complaint	Level of Complaint Review	Days to Receive Decision	Additional Information
Prospective	First-level (internal)	30 days	Prospective health services means that you have not received the services yet. If we are unable to make the decision due to reasons out of our control, we will notify you that the decision will be made within an additional 10 days. We will also let you know the reason for the delay.
Retrospective	First level (internal)	60 days	Retrospective health services means that you have already received the services.
Urgent	First (internal) - or second-level (external review)	72 hours	Expedited is when there is potential danger to your health. See the section on urgent complaints for more information. If the urgent complaint is concurrent, meaning you are receiving services at this time, you will not be responsible for charges related to the complaint from the time you submit the complaint until a decision has been made.
All Levels of Appeal	Second-level external review	Up to 45 days (determined by Independent Review Organization)	Independent Review Organization will notify you, your authorized representative and Avera Health Plans of the process and any fees that may apply.

Note: For purposes of calculating the time periods within which a decision is made and notice provided, the time period will begin on the date the request for review is received by us in accordance with our procedures for filing a request. It will not matter if all of the information necessary to make the determination is included in the filing.

What If I Want to Know More About the Process?

If you want to know more, please call our Service Center for a free copy of our Complaint Policy. The policy provides more information than what is outlined in this document.

When Another Party Is Responsible for Payment of Injury or Illness

When another party is responsible for payment of an injury or illness, we have the right to recover the amount paid to you or paid for medical services you received. This process is called subrogation.

How Do We Handle Payment?

If you receive an injury or illness because of something someone else did, or didn't do, we cover benefits as we usually do. But if you get money back from someone else, you need to repay Avera Health Plans for expenses we covered for you. Even if you don't choose to file a claim against the responsible party, we can do so and you must help us by giving us any information we need. You cannot do anything to prevent us from recovering our money.

For example, if you are hurt in a car accident and need medical treatment, we will pay for covered health services. But if it turns out that either you or the other driver has auto insurance that could pay for your medical expenses, we can pursue getting money back from either or both of those insurance companies. In such a case, the auto insurance company generally has the first responsibility for those costs, not us. We pay initially so that you don't have to wait for auto insurance companies.

How Do We Recover Expenses Initially Paid by Us?

If you file a lawsuit or other legal action against someone responsible for your injury or illness and receive money back, we can require that you reimburse us up to the amount we paid on your behalf. You must give us information on any such action, including letting us know when you file a lawsuit or other legal action. You must also tell us about any proposed settlement with another party.

If you do file a lawsuit, you must include a claim for expenses we paid on your behalf and allow us to participate in the lawsuit. As stated above, if you don't file to receive money from the other party, we can still do so. You must help us in the process.

We use a company that asks for information on your injury or illness and follows up on third-party settlements. You must complete and return any requested forms to help us pursue our share of any money. If you are concerned about privacy and have a question about someone asking you for information on our behalf, please call our Service Center.

Legal Statement Regarding Subrogation

Avera Health Plans' right of recovery will be a prior lien against any proceeds you recover. Our rights will not be defeated or reduced by the application of any so-called "Made-Whole Doctrine," or any other such doctrine purporting to defeat our recovery rights by allocating the proceeds

exclusively to non-medical damages or by making Avera Health Plans' rights subject to your having been made whole.

You must not incur any expenses on behalf of Avera Health Plans in pursuit of Avera Health Plans' rights. No court costs or attorney's fees may be deducted from Avera Health Plans' recovery unless we agree in advance in writing. Avera Health Plans' recovery will not be reduced by applying any so-called "Fund Doctrine," "Common Fund Doctrine," "Attorney's Fund Doctrine" or any similar doctrine or approach.

Avera Health Plans will recover the full amount of benefits it paid without regard to any claim or fault on the part of any beneficiary, whether under comparative negligence or otherwise.

Eligibility and Enrollment

Am I Eligible for Coverage?

You are eligible for coverage when you meet your employer's eligibility criteria (such as a full-time employee).

Is My Dependent Eligible for Coverage?

1. Your spouse is eligible for coverage.

2. Your dependent child or disabled dependent is eligible if:

   - He or she is under the age of 26 or
   - He or she is 26 through 29 years old and enrolled in and attending an accredited college, university, or trade or secondary school on a full time basis.* He or she must remain a continuous full-time student through the age of 29 and not have other creditable coverage.

     *The school's definition of full-time student will be used to determine eligibility. A student who is unable to carry a full-time course load because of illness, injury, or physical or mental disability will be considered a full-time student if: (1) the disability is documented by a physician and (2) the course load is 60% of what the school considers full-time.

   - He or she is incapable of self-sustaining employment and mainly dependent on you for care and supervision because of a physical or mental disability that was present before he or she was 26 (or 29, if a full-time student). You may need to provide proof of the disability within 31 days of our request according to our policy.

Exception: If you and your spouse are both covered as subscribers under this Certificate of Coverage then:

- Your spouse cannot be a dependent on your policy,
- You cannot be a dependent on your spouse's policy and
- Your dependent children can only be covered on one policy, not both your policy and your spouse's policy.

TIP

For dependents under the age of 26, the following will not be considered in determining eligibility for initial or continued coverage:

- marital status,
- financial dependency,
- residency,
- student status or
- employment status

Limitations: Your dependent will not be covered under this Certificate of Coverage if:

- He or she is eligible to be a subscriber and is already covered as a dependent of another subscriber or
- He or she is already covered as a subscriber.

What If My Dependent Child Becomes Ill or Injured While Enrolled in College, a University or a Trade/Vocational School?

If your dependent child is 26 through 29 years old and enrolled in and attending an accredited college, university, or trade or secondary school on a full-time basis, he or she may qualify to take a medically necessary leave of absence and keep his or her health care coverage for up to 12 months. Michelle's Law applies to students enrolled in post-secondary education (college, a university or a trade/vocational school). The law allows students who become seriously ill or injured to change enrollment status or to leave school without losing coverage under their parent's plan. Students who take a "medically necessary leave of absence" can keep their coverage for up to 12 months after they take the leave of absence.

A medically necessary leave of absence from a post-secondary educational institution:

- Begins while the student is suffering from a serious illness or injury,
- Is medically necessary and
- Causes the student to lose eligibility as a covered dependent.

To qualify for a medically necessary leave of absence, you must send us written notification from the physician who is treating your dependent child. The written notification must state:

- He or she is suffering from a serious illness or injury and
- The leave of absence is medically necessary.

When Can I Enroll?

You have three opportunities to enroll for health care coverage after you have met your employer's eligibility criteria.

Opportunities to Enroll	When To Enroll	Effective Date
Initial Enrollment Period	Starts on the day you become an eligible group member and ends 30 days later.	Coverage generally becomes effective on the first day of the month following completion of your employer's waiting period.
Open Enrollment Period Please note: If your employer offers more than one benefit plan, you are able to change plans during the open enrollment period. The change	An open enrollment period is defined by your employer and us. Some employers do not offer open enrollment.	Coverage becomes effective on the open enrollment date chosen by your employer.

will become effective on the open enrollment effective date.		
Special Enrollment Period See the following conditions.	• Loss of other creditable coverage • Newly acquired dependents • Court-ordered coverage	See the following conditions for effective dates.

You have the option of declining medical coverage for you and your family. If you decline, you cannot enroll until the next open enrollment period (if one is offered by your employer). Contact your employer to find out if and when your open enrollment period begins.

Special Enrollment Conditions

Loss of Other Creditable Coverage: A special enrollment period will apply if:

1. You were covered under other creditable coverage at the time of initial eligibility, and stated in writing you declined enrollment only because you had other coverage and

2. The creditable coverage terminated due to loss of:

   - Eligibility – such as loss due to divorce or legal separation, death, termination of employment or reduction in work hours (exceptions: loss of eligibility does not include a loss due to failure of the person to pay premiums on a timely basis or termination of coverage for causes such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the health coverage),
   - Termination of employer contributions, or if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation.

3. Request for enrollment is made within 30 days after the other coverage terminates. If your loss of creditable coverage is due to becoming ineligible for Medicaid or the CHIP program, you have 60 days to request enrollment.

Your effective date of coverage will be no later than the first of the month after your request for enrollment is made.

Newly Acquired Dependents: A special enrollment period will apply if:

- A person becomes your dependent through marriage, birth, adoption or placement for adoption and
- You request enrollment within 31 days after the date of the marriage, birth, adoption or placement for adoption.

Note: If you already have other children covered on your policy, you have 90 days from birth or adoption or placement of adoption to submit an Enrollment Application to enroll your child. The effective date of your dependent(s) coverage will be:

ALERT

If adding a newborn to your policy, you must fill out an Enrollment Application within 31 days of your baby's birth (or 90 days if you already have other children covered on your policy). This will ensure that the newborn's effective date of coverage is the date of birth.

Event	Effective Date
Marriage	No earlier than the date of marriage and no later than the first of the month after request for enrollment per your employer's guidelines
Dependent child's birth	Date of birth
Dependent child's adoption or placement for adoption.	Date of adoption or placement for adoption, whichever is earlier

Court-Ordered Coverage: A special enrollment period will apply if you are required by a court or administrative order to provide health coverage.

The effective date of your dependent(s) coverage will be no later than the first of the month after the request for enrollment is made.

Exception: If a court has ordered you to provide health coverage for a dependent child and you fail to enroll the dependent child, the other parent may enroll the dependent child on your plan.

A dependent child who is provided coverage according to this exception will not be terminated unless we receive written evidence of any of the following:

- The court or administrative order is no longer in effect.
- The dependent child is or will be enrolled in comparable health coverage through an insurer which will take effect no later than the effective date of the termination.
- The group has eliminated family coverage for all of its members.

How Do I Enroll and How Do I Enroll My Dependents?

You Must:	Your Employer Must:
• Complete and sign our Enrollment Application form requesting coverage for you and any dependents, and • Provide all information needed to determine your eligibility and the eligibility of any dependents.	• Submit a written request for eligible group members, • Provide to us all necessary information to determine eligibility, and • Agree to pay the required premiums on behalf of the eligible group members.

Termination

When Does Coverage End?

Termination by You

You may terminate coverage for you or any dependents by notifying us in writing. Your notification has to be received prior to the date of termination and should be approved by your employer. You will be responsible for any premiums through the date of termination.

Please note: If you are under a **Section 125 Cafeteria Plan or Flexible Spending Account**, please contact your employer to verify your termination requirements.

If you are terminating your spouse's coverage but your spouse remains an eligible dependent, your spouse must provide written consent for termination. Termination will be the last day of the month in which we receive a signed consent.

TIP

Your spouse must provide written consent if you are terminating his or her coverage and he or she remains an eligible dependent.

Termination by Us

We may terminate your coverage for any of the reasons listed below. We will notify you in writing of the reason for termination and the effective date.

Reason	Description	Termination Date
Failure to Pay Required Payments	You or your employer fails to pay required payments by the due date.	Immediately
Fraud or Intentional Misrepresentations	You or your employer intentionally misrepresents or conceals a fact on your application or other health plan documents.	Immediately *Note: We will recover any paid claims, less the premiums paid, back to the date of the event.*
Eligibility	You become ineligible for coverage based on your employer's eligibility guidelines.	Contact your employer for your termination date.

Too Few Employees	The number of employees covered under this plan drops below the number or percentage required to be on this plan.	Contact your employer for your termination date.
Non-Renewal of a Plan by Us	We decide to not renew any health benefit plans to any employers in South Dakota.	We will notify your employer prior to termination.
Employer No Longer Part of Association	Your employer was part of an association that offered insurance coverage and is no longer part of that association.	Immediately *Note: Coverage termination will not be due to a health-status-related factor.*
We Stop Offering a Type of Insurance	We stop offering a particular type of health insurance in this market. We will notify your employer at least 90 days before coverage is terminated. Your employer will have the option to select a different plan that we are continuing to offer in this market.	90 days after your employer receives notice *Note: Coverage termination will not be due to a health-status-related factor.*

Group Termination

If your group is terminated, your employer will provide you with written notice within 10 days of the termination date. For purposes of this Certificate of Coverage, to give written notice means to present the notice to you or mail it to your last known address.

What If I Disagree With My Termination?

You may file a complaint in writing regarding our decision to terminate or not renew your coverage. You or your dependents will not be terminated due to the status of your health or because you have filed a complaint.

Even if you file a complaint, your coverage will terminate on the date indicated on the initial letter. You may extend your coverage if you qualify for continuation of coverage (see the following section, Continuation of Coverage). If the decision is in your favor, coverage will be reinstated with no break in coverage.

What Happens After Coverage Ends?

You or your dependent whose coverage has ended may be eligible for one or more of the following options:

Temporary Extension of Coverage

If Hospitalized:

This option exists to cover a member who is hospitalized at the time that coverage is terminated. In this case, coverage under this Certificate of Coverage will continue until the earlier of:

- 30 days after termination of coverage,
- The date of the member's discharge from the hospital or
- The date the member becomes covered under other health care coverage.

NOTE**:** In the event that your coverage is terminated due to our insolvency, coverage will continue for the duration of the period for which premiums have been paid and until members who are confined on the date of insolvency in an inpatient facility until their discharge or expiration of benefits.

Continuation of Coverage

Both state law and federal law (the federal law is known as COBRA) allow you and your covered dependents to continue coverage under an employer group health plan after your employment ends or if certain other events occur. These laws apply to employers and not directly to Avera Health Plans. If your employer changes from Avera Health Plans to another health plan, including a self-insured plan, you have the right to continue under COBRA with your employer's new plan. Your COBRA plan will transfer with you to the new health plan.

You need to be aware that you have rights to continue coverage if your employment ends or if certain other events occur. This section is for your information only and is not an obligation of Avera Health Plans.

If you qualify for state Continuation of Coverage, we process this coverage the same as COBRA coverage.

FOR MORE INFORMATION

If you have questions on whether you qualify for COBRA coverage, please contact our Service Center.

COBRA

You and your covered dependents have a right to continue coverage if you have a qualifying event listed below.

Continuation of coverage also applies to a covered dependent such as a child born to or placed for adoption with you after a qualifying event has occurred. The child must be added within the time frames stated in this Certificate of Coverage.

Qualifying events include:

For You:	**For Your Dependents:**
• Employment ends for any reason other than for gross misconduct or • Hours of employment are reduced.	• Employee dies, • Employee's hours of employment are reduced, • Employee's employment ends for any reason other than for his or her gross misconduct, • Employee becomes entitled to Medicare benefits (under Part A, Part B, or both), • Divorce or legal separation or • Loss of dependent status.

Please contact your employer to verify your eligibility date for your COBRA coverage.

How Long Do I Have COBRA Coverage?

The length of COBRA coverage depends on the qualifying event and may be extended based on events that take place during your COBRA coverage.

Qualifying Event	Covered Member	Length of COBRA Coverage	Your Premium Responsibility*
• Loss of employment or reduction of hours	Employee Spouse Dependent Child	Up to 18 months	102%
- With Social Security disability determination prior to or within the first 60 days of COBRA coverage		Up to a total of 29 months	150%
• Employee dies • Divorce or legal separation • Loss of dependent status • Employee becomes entitled to Medicare	Spouse Dependent Child	Up to 36 months	102%

*You pay the entire premium amount, that is, the portion you paid as an active employee plus the amount your employer paid for your coverage. In addition, you pay a 2% administration fee.

How Does Medicare Enrollment Affect COBRA Coverage?

If you enroll in Medicare while you and your dependents are covered under COBRA, your dependents may be eligible for up to 36 months of COBRA coverage. The 36 months start from the effective date of your COBRA coverage.

If you enroll in Medicare before a qualifying event, your covered dependents can elect to continue COBRA coverage for up to the longer of either:

- 18 months from the loss of your employment or
- 36 months from your original Medicare eligibility date.

How Do I Enroll and Pay for COBRA Coverage?

If you decide to continue coverage, you must complete your COBRA election form and return it to the address below within 60 days from your loss of coverage date due to the qualifying event or from the date you were notified of your COBRA rights, whichever is later.

The chart below is only an example.

Date Your Coverage Ends	Date Your COBRA Notification is Sent	Timeline to Elect COBRA
July 31	July 1	60 days from July 31
July 31	August 15	60 days from August 15

For the length of time you remain on COBRA coverage, you are responsible for the premiums. Your initial premium is due within 45 days after you sign the COBRA election form. All other premiums are due the first of every month. Premium payments must be made payable to Avera Health Plans and mailed to:

Avera Health Plans
PO Box 826
Sioux Falls, SD 57101-0826

ALERT

Your COBRA premium is due the first day of each month.

If payment is not received within 30 days of the due date, coverage will be terminated. Once coverage is terminated, it cannot be reinstated.

Am I Able to Extend My COBRA Coverage?

You may be able to extend your COBRA coverage if you or your covered dependents have another qualifying event that takes place while you are covered under COBRA (see section, How Long Do I Have COBRA Coverage?). You must notify us within 60 days of the second qualifying event to request an extension of COBRA coverage.

TIP

If you choose to cancel your COBRA coverage or your coverage is terminated due to non-payment, your COBRA coverage cannot be reinstated.

When Does My COBRA Coverage End?

Your COBRA coverage will end immediately if:

- You fail to pay the required premium,
- You become covered under another group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition that you may have,
- You or your dependents enroll in Medicare. At that time, coverage ends for each person covered under Medicare or
- All of your employer's group health plans are terminated.

What If My Employer Changes Benefits While I Have COBRA Coverage?

If your employer changes benefits, your COBRA benefits will also change to match your employer's new benefit package.

As a COBRA member, you have the same right to change benefit plans as an employed group member. If an employed group member is allowed to change from Plan A to Plan B during the group's open enrollment period, you are allowed the same opportunity.

If your employer changes insurers, your COBRA coverage will also change to the new insurer.

TIP

For more information on COBRA, please see the General Notice of COBRA Continuation Coverage Rights. This notice is found in the General Provisions Section.

General Provisions

Contract

On our website, www.AveraHealthPlans.com you will have access to all documents that make up your contract (this Certificate of Coverage, your Benefit Summary and other documents). All statements made by you under this Certificate of Coverage will be considered as representations and not warranties.

Individual Benefit Management Program

In certain situations, you may qualify for an Individual Benefit Management Program. The Individual Benefit Management Program is a contract between us, you and your providers necessary to meet your care needs in a case specific plan. This contract allows for individual consideration of alternate benefits.

Release of Information

We may require you to give information such as medical or other records when needed to determine eligibility, administer benefits or process claims. We could deny coverage if you don't provide the information when requested.

Women's Health and Cancer Rights Act of 1998

On October 21, 1998, Congress enacted the Women's Health and Cancer Rights Act of 1998. This notice explains the most important provisions of the Act. Please review this information carefully. If your spouse is covered by Avera Health Plans, please make certain she or he also has the opportunity to review this information.

The Women's Health and Cancer Rights Act of 1998 requires all group health plans that provide medical and surgical benefits for a mastectomy to provide coverage for:

- Reconstruction of the breast on which the mastectomy has been performed,
- Surgery and construction of the other breast to produce a symmetrical appearance and
- Prostheses and coverage for any complications in all stages of mastectomy, including lymphedemas.

The Act requires coverage be provided in a manner that is "consistent" with other benefits provided under the Plan. The coverage may be subject to annual deductibles and coinsurance provisions.

The Act prohibits any group health plan from:

- Denying a participant or a beneficiary eligibility to enroll or renew coverage under the plan in order to avoid the requirements of the Act,
- Penalizing, reducing, or limiting reimbursement to the attending provider

(e.g., physician, clinic, or hospital) to induce the provider to provide care inconsistent with the Act, and
- Providing monetary or other incentives to an attending provider to induce the provider to provide care inconsistent with the Act.

The Women's Health and Cancer Rights Act of 1998 applies to benefits provided by Avera Health Plans. Please keep this information with your other group health plan documents. If you have any questions about coverage of mastectomies and reconstructive surgeries, please contact Avera Health Plans at (605) 322-4545 or toll-free at 1 (888) 322-2115.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

ERISA Plans

You may be entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Health Plan Participants shall be entitled to:

- Examine, without charge, at the Administrator's office all Health Insurance Plan documents, insurance contracts and copies of all documents filed by the Health Insurance Plan with the U.S. Department of Labor, such as detailed annual reports and this Certificate of Coverage;
- Obtain copies of all Health Insurance Plan documents and other Health Insurance Plan information upon written request to the Administrator, who may make a reasonable charge for the copies; and
- Receive a summary of the Health Insurance Plan's annual financial report. The Administrator is required by law to annually furnish each Participant with a copy of this summary annual report.

In addition to creating rights for Health Insurance Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. These people, called "fiduciaries" of the Plan, have a duty to act prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including the Company or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a Health Insurance Plan benefit or exercising your rights under ERISA.

If your claim for a Health Insurance Plan benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Health Insurance Plan's Administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Health Insurance Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case,

the court may require the Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Health Insurance Plan fiduciaries misuse the Health Insurance Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; if, for example, it finds your claim is frivolous.

If you have any questions about your Health Insurance Plan, you should contact the Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the Administrator or the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Ave., NW, Washington, DC 20210.

Privacy Notice

Avera Health Plans Privacy Commitment

Avera Health Plans, Inc. does not sell or disclose any nonpublic personal information or nonpublic personal financial information about its subscribers or members to any companies not affiliated with Avera Health Plans, Inc., or to anyone else, except as required by law.

The Type of Information We Collect

Avera Health Plans, Inc. ("Avera Health Plans") collects both nonpublic personal financial and nonpublic personal information about subscribers and members on application forms, through telephone requests, and through other forms of communication, such as letters. This information is needed to underwrite the policy, process claims, provide follow-up care with an insured and provide the optimum level of cost effective health care. "Nonpublic personal financial information" includes, for example, any list of individual names and street addresses that is not publicly available, social security numbers, policy account numbers, and salary information. "Nonpublic personal information" includes health information which can be a person's past, present, or future physical, mental or behavioral health condition.

Avera Health Plans shall maintain the privacy, security and confidentiality of all nonpublic personal information transmitted or received through or maintained in connection with its contractual relationship in accordance with (i) all applicable statutes and regulations, including without limitation the applicable requirements, regulations and policies, and advisory opinions, from time to time promulgated and published there under and with respect thereto as from time to time amended, and (ii) the protocols, rules, policies and other requirements of accrediting agencies, licensors and authorities that are applicable to the operation of Avera Health Plans. Avera Health Plans restricts access to nonpublic personal financial and nonpublic personal information that it has obtained to those employees or affiliated companies under contract who need to know such information to provide timely and accurate claims processing, utilization management, quality control, and cost effective follow-up patient care. Avera Health Plans maintains policies and procedures that comply

with federal regulations to guard your nonpublic personal and financial information from improper disclosures.

This Privacy Notice is available on Avera Health Plans website at www.AveraHealthPlans.com. If you have any questions about this Privacy Notice, call Avera Health Plans at (605) 322-4545 or contact us at 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105.

Notice of 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.

This notice will tell you how Avera Health Plans, Inc. (hereafter collectively referred to as the "Company") may use and disclose protected health information. Protected health information means any health information that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In this notice, we'll refer to protected health information simply as "medical information."

This notice will describe your rights and the Company's duties with respect to your medical information. In addition, it will describe how to file a complaint if you believe the Company has violated your privacy rights.

The Company May Use and Disclose Your Medical Information for the Following Reasons:

• For Treatment

To coordinate or manage health care and related services by both the Company and health care providers, your medical information may be disclosed to doctors, nurses, hospitals and other health facilities that become involved in your care. In addition, other health care providers may be given your medical information, such as medical consultants or specialists to which you have been referred. If the Company refers you to a physician, it also will contact that physician's office and provide medical information about you so the physician has information needed to provide quality services.

• For Payment

To process your claims for payment. This can include paying your health care providers, transactions with our reinsurance company, business associates that are contracted to perform or assist the Company, third party payors, or transactions with you. For example, the Company may need to get medical information from your health care provider to pay your bill or reimburse you for amounts you have paid. The Company also may need to provide medical information to a government program, such as Medicare or Medicaid, to determine your eligibility for a program.

• For Health Care Operations

Health care operations are necessary for the Company to maintain quality operations for our Members. For example, medical information about you may be used to offer optional treatments or pharmaceuticals. Medical information about you may be used to train Company staff. The Company may also use medical information to study ways to more efficiently manage our organization.

• How the Company Will Contact You

Unless you inform us otherwise in writing, the Company may contact you by either telephone or by mail at either your home or your office. At either location, the Company may leave messages for you on an answering machine or voice mail. If you want to request that the Company communicates to you in a certain way or at a certain location, see the Right to Receive Confidential Communications section of this notice.

• Appointment Reminders

To remind you about your appointments with our Case Management Nurses or other representatives.

• Treatment Alternatives

To contact you about treatment alternatives that may be of interest to you.

• Health-Related Benefits and Services

To contact you about health-related benefits and services that may be of interest to you.

• Individuals Involved in Your Care

The Company may disclose to a family member, other relative, a close personal friend or any other person identified by you, medical information that is directly relevant to that person's involvement with your care or payment related to your care. The Company also may use or disclose medical information to notify, or assist in notifying, those persons of your location, general condition or death. If there is a family member, other relative, or close personal friend that you do not want the Company to disclose your medical information to, you must notify the Avera Health Plans Service Center at 1 (888) 322-2115 prior to any release of information occurring.

• Reports to Your Plan Sponsor

If you are in a self-insured plan, the Company will disclose to your designated plan sponsor representative(s) any of the following information upon request:

- Whether an individual who works for the plan sponsor, or that individual's family member, is currently participating in the plan sponsor's group health plan,

- When an individual who works for the plan sponsor, or that individual's family member, enrolls or dis-enrolls from the plan sponsor's group health plan, or

- Summary medical information will only be released upon request from the plan sponsor for the purposes of:
    - Obtaining a premium bid.
    - Modifying, amending or terminating the group health plan.

The only time the Company will disclose medical information to your plan sponsor is after the plan sponsor has contractually agreed to all HIPAA requirements and has its own HIPAA policies and procedures to protect your medical information.

• Disaster Relief

To disclose medical information about you to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. This will be done to coordinate with those entities in notifying a family member, other relative, close personal friend or other person identified by you of your location, general condition or death.

• Required by Law

The Company may use or disclose medical information when we are required to do so by law.

• Public Health Activities

The Company may disclose medical information for public health activities and purposes. This includes reporting medical information to a public health authority that is authorized by law to collect or receive the information for purposes of preventing or controlling disease, or one that is authorized to receive reports of child abuse and neglect.

• Victims of Abuse, Neglect or Domestic Violence

To a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if the Company believes you are a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is:

- Required by law,
- Agreed to by you, or

Authorized by law and we believe the disclosure is necessary to prevent serious harm to you or to other potential victims; or, if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

• Health Oversight Activities

To a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight of the health care system, government benefit programs, and entities subject to various government regulations.

• Judicial and Administrative Proceedings

In response to an order of the court or administrative tribunal. The Company also may disclose medical information in response to a subpoena, discovery request, or other legal process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

• Disclosures for Law Enforcement Purposes

To law enforcement officials for law enforcement purposes:

- As required by law,
- In response to a court, grand jury or administrative order, warrant or subpoena,
- To identify or locate a suspect, fugitive, material witness or missing person,
- About an actual or suspected victim of a crime and that person agrees to the disclosure. If we are unable to obtain that person's agreement, in limited circumstances, the information may still be disclosed,
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct,
- About crimes that occur at our facility,
- To report a crime in emergency circumstances.

• Research

Before the Company discloses medical information for research, the research will have been approved through a process that evaluates the needs of the research project with your need for privacy. The Company may, however, disclose medical information about you to a person who is preparing to conduct research, but no medical information will leave the Company during that person's review of the information.

• To Avert Serious Threat to Health or Safety

If the Company believes the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public. The Company also may release information about you if it believes the disclosure is necessary for law enforcement authorities to identify or apprehend an individual who admitted participation in a violent crime or who is an escapee from a correctional institution or from lawful custody.

• Military

If you are a member of the Armed Forces, the Company may use and disclose your medical information for activities deemed necessary by the appropriate military command authorities to assure the proper execution of the military mission. The Company may also release information about foreign military personnel to the appropriate foreign military authority for the same purposes.

• National Security and Intelligence

To authorized federal officials for the purpose of national security activities or for the protection activities of certain U.S. or foreign federal employees as authorized by law.

• Inmates; Persons in Custody

To a correctional institution or law enforcement official having custody of you. The disclosure will be made if the disclosure is necessary: (a) to provide health care to you; (b) for the health and safety of others; or, (c) the safety, security and good order of the correctional institution.

• Workers' Compensation

To the extent necessary to comply with workers' compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

• Other Uses and Disclosures

Other uses and disclosures will be made only with your written authorization. You may revoke such an authorization at any time by writing to: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105. However, if you revoke your authorization, it will not have any effect on actions already taken by us.

Your Rights With Respect to Medical Information About You

You have the following rights with respect to medical information that the Company maintains about you:

• Right to Request Restrictions
To request that the Company restrict the uses or disclosures of medical information about you to carry out treatment, payment, or health care operations. You also have the right to request that the Company restrict the uses or disclosures we make to:

- A family member, other relative, a close personal friend or any other person identified by you, or
- Public or private entities for disaster relief efforts. For example, you could ask that we not disclose medical information about you to your brother or sister.

To request a restriction, you may do so at the time you complete your consent form or at any other time. If you request a restriction after you have completed the initial consent form, you should do so in writing by mailing the request to: Avera Health Plans, Attn: Restriction Request, 3816 S. Elmwood Ave., Suite 100 Sioux Falls, SD 57105 and tell us:

- What information you want to limit,
- Whether you want to limit use or disclosure or both and
- To whom you want the limits to apply (for example, disclosures to your spouse).

The Company is not required to agree to any requested restriction. However, if the Company does agree, it will follow that restriction unless the information is needed to provide emergency treatment. Even if the Company agrees to a restriction, either you or the Company can later terminate the restriction.

• Right to Receive Confidential Communications

You have the right to request how or where the Company communicates to you. For example, you can ask that the Company only contact you by mail or at work. The Company will not require you to tell us why you are making the request. If you want to make a special request you must do so by sending your request in writing to: Avera Health Plans, Attn: Confidential Communications Request, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105. Your request must state how or where you can be contacted. The Company will accommodate your request. However, the Company may, when appropriate, require information from you concerning how payment will be handled.

• Right to Inspect and Copy

With a few very limited exceptions, such as psychotherapy notes, you have the right to inspect and obtain a copy of your medical information. For medical information that the Company has obtained from your provider(s), we ask that you make the request directly to the provider. To inspect or copy medical information about you that the Company has created, you must submit your request in writing to: Avera Health Plans, Attn: Inspect/Copy Request, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105. Your request should state specifically what medical information you want to inspect or copy. If you request a copy of the information, the Company may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing. The Company will act on your request within thirty (30) calendar days after it receives your request. If the Company grants your request, in whole or in part, it will inform you of its acceptance and provide access and copying. The Company may deny your request to inspect and copy if the medical information involved is:

- Psychotherapy notes,
- Information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding.

If the Company denies your request, it will inform you of the basis for the denial, how you may have our denial reviewed, and how you may file a complaint. If you request a review of our denial, it will be conducted by a licensed health care professional designated by the Company who was not directly involved in the denial. The Company will comply with the outcome of that review.

• Right to Amend

You have the right to ask to have amended the medical information about you in the Company's possession. This right is for as long as the Company maintains the medical information. For information that the Company has obtained from your provider(s) about you, the Company asks that you make the request to them. It is the Company's policy that it does not amend information that it did not originate. To request an amendment, you must submit your request in writing to: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105. Your request must state the amendment desired and provide a reason in support of that amendment. The Company will

act on your request within sixty (60) calendar days after it receives your request. If the Company grants your request, in whole or in part, it will inform you of its acceptance of your request and provide access and copying. If the Company grants the request, in whole or in part, it will seek your identification and agreement to share the amendment with other entities. The Company also will make the appropriate amendment to the medical information by appending or otherwise providing a link to the amendment.

The Company may deny your request to amend medical information about you. The Company may deny your request if it is not in writing and does not provide a reason in support of the amendment. In addition, the Company may deny your request to amend medical information if it determines that the information:

- Was not created by the Company, unless the person or entity that created the information is no longer available to act on the requested amendment,
- Is not part of the medical information maintained by the Company,
- Would not be available for you to inspect or copy or
- Is accurate and complete.

If the Company denies your request, it will inform you of the basis for the denial. You will have the right to submit a statement disagreeing with our denial. Your statement may not exceed two pages. The Company may prepare a rebuttal to that statement. Your request for amendment, the Company's denial of the request, your statement of disagreement, if any, and our rebuttal, if any, will then be appended to the medical information involved or otherwise linked to it. All of that will then be included with any subsequent disclosure of the information, or, at our election, may include a summary of any of that information.

If you do not submit a statement of disagreement, you may ask that the Company include your request for amendment and our denial with any future disclosures of the information.

The Company will include your request for amendment and our denial (or a summary of that information) with any subsequent disclosure of the medical information involved. You also have the right to complain about the Company's denial of your request.

• Right to an Accounting of Disclosures

You have the right to receive an accounting of your medical information disclosures. The accounting may be for up to six (6) years prior to the date on which you request the accounting, but not before April 14, 2003. Certain types of disclosures are not included in such an accounting:

- Disclosures to carry out treatment, payment and health care operations,
- Disclosures of your medical information made to you,
- Disclosures authorized by you,
- Disclosures for national security or intelligence purposes,
- Disclosures to correctional institutions or law enforcement officials.

Under certain circumstances your right to an accounting of disclosures may be suspended for disclosures to a health oversight agency or law enforcement official. To request an accounting of

disclosures, you must submit your request in writing to: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105. Your request must state a time period for the disclosures. It may not be longer than six (6) years from the date we receive your request and may not include dates before April 14, 2003. The Company will act on your request within sixty (60) calendar days after it receives your request. Within that time, the Company will either provide the accounting of disclosures to you or give you a written statement of when the Company will provide the accounting and why the delay is necessary. There is no charge for the first accounting we provide to you in any twelve (12) month period. For additional accountings, the Company may charge you for the cost of providing the list.

If there will be a charge, the Company will notify you of the cost involved and give you an opportunity to withdraw or modify your request to avoid or reduce the fee.

• Right to a Copy of This Notice

You have the right to obtain a paper copy of the Company's Notice of Privacy Practices at any time. You may obtain a copy of the Company's Notice of Privacy Practices on the Internet at **www.AveraHealthPlans.com.** To obtain a paper copy, mail a request to: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105 or call 1 (888) 322-2115.

The Company's Duties

• Generally

The Company is required by law to maintain the privacy of medical information about you and to provide individuals with notice of our legal duties and privacy practices with respect to medical information. We are required to abide by the terms of our Notice of Privacy Practices in effect at the time.

• Our Right to Change Notice of Privacy Practices

The Company reserves the right to change this Notice of Privacy Practices. The Company reserves the right to make the new notice's provisions effective for all medical information which is created or received by us, prior to the effective date of the new notice.

• Availability of Notice of Privacy Practices

A copy of the Company's current Notice of Privacy Practices will be available at our corporate offices as well as on our web site, www.AveraHealthPlans.com. At any time, you may obtain a copy of the current Notice of Privacy Practices by mail at: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105 or call 1 (888) 322-2115.

• Complaints

You may complain to the Company and to the United States Secretary of Health and Human Services, Office of Civil Rights, if you believe your privacy rights have been violated. To file a complaint with the Company, contact: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux

Falls, SD 57105. All complaints should be submitted in writing. To find your HHS regional office, please call the Avera Health Plans Service Center at 1 (888) 322-2115. You will not be retaliated against for filing a complaint.

• Questions and Information

If you have any questions or want more information concerning this Notice of Privacy Practices, please contact by mail: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105, or call (605) 322-4545 or toll-free at 1 (888) 322-2115.

General Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you are covered under a group health plan (the Plan). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Certificate of Coverage or contact the Plan Administrator.

What Is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in the notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies,

- Your spouse's hours of employment are reduced,
- Your spouse's employment ends for any reason other than his or her gross misconduct,
- Your spouse becomes enrolled in Medicare (Part A, Part B, or both) or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies,
- The parent-employee's hours of employment are reduced,
- The parent-employee's employment ends for any reason other than his or her gross misconduct,
- The parent-employee becomes enrolled in Medicare (Part A, Part B, or both),
- The parents become divorced or legally separated or
- The child stops being eligible for coverage under the Plans as a dependent child.

When Is COBRA Coverage Available?

The Plan will offer COBRA continuation to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event. In addition, if the Plan provides retiree health coverage, then commencement of a proceeding in a bankruptcy with respect to the employer is also a qualifying event where the employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice to:

Avera Health Plans
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

How Is COBRA Coverage Provided?

After the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin either (1) on the date of the qualifying event or (2) on the date that Plan coverage would otherwise have been lost, depending on the nature of the Plan. Covered employees may elect COBRA continuation coverage on behalf of their spouses and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, your divorce or legal separation, a dependent child losing eligibility as a dependent child, or the employee's becoming enrolled in Medicare benefits (under Part A, Part B, or both), COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA continuation coverage for the Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator within 60 days after the date of the determination and before the end of the first 18 months of COBRA coverage, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. This notice should be sent to:

Avera Health Plans
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. This extension may be available to the spouse and dependent children receiving continuation coverage if the former employee dies, becomes enrolled in Medicare benefits (under Part A, Part B or both) or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child**,** but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.
In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:

Avera Health Plans
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538

Trade Act of 2002

If you qualify for Trade Adjustment Assistance (TAA) as defined by the Trade Act of 2002, then you will be provided with an additional 60-day enrollment period, with continuation coverage beginning on the date of such TAA approval.

If You Have Questions

Questions about your COBRA continuation coverage should be addressed to the contact(s) identified below. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at **www.dol.gov/ebsa.**

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Contact Information

Avera Health Plans
3816 S. Elmwood Ave., Suite 100
Sioux Falls, SD 57105-6538
(605) 322-4545 or 1 (888) 322-2115