2018

Individual Health Insurance Policy

South Dakota | Qualified Health Plan

Avera Health Plans

Live better. Live balanced. Avera.

Avera MyPlan

Individual Health Benefits Policy
South Dakota

Avera Health Plans, Inc.

This Policy may be renewed for additional terms by the timely payment of the required Premium, subject to the termination provisions in this Policy.

If you are not satisfied with the Policy for any reason, you have the right to cancel this Policy within 10 days of delivery and to have the premium refunded. The Policy will then be considered void from the beginning. If we have paid claims for you during this inspection period, we have the right to recover any amounts we have paid.

A Policy between Avera Health Plans, Inc., a South Dakota Health Maintenance Organization

Located at

3816 S Elmwood Ave., Suite 100
Sioux Falls, SD 57105

And

_____
(Herein referred to as Policyholder)

Avera Health Plans agrees to provide payment for the health services set forth within this Policy to eligible Members and their Eligible Dependents, subject to the exclusions, limitations, conditions, and other terms of this Policy.

This Policy is delivered in and governed by the laws of the state of South Dakota. If any one part is not in compliance with South Dakota law, it will not void the entirety of the Policy.

Executed by Avera Health Plans, Inc., at Sioux Falls, South Dakota.

Debra Muller

_____
Debra Muller
Chief Administrative Officer

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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. Your Avera *MyPlan* Individual Health Benefits Policy, explains your benefits according to the laws of the state of South Dakota. Please review this document carefully so you can take advantage of your benefits.

This Avera *MyPlan* Individual Health Benefits Policy ("Policy"), including benefit options, your application, the Summary of Benefits and Coverage, your identification card, and attachments, constitutes the entire contract of insurance. No change in this Policy is valid until approved by an executive officer of Avera Health Plans and unless such approval is endorsed or attached to this Policy. No insurance producer has authority to change this Policy or to waive any of its provisions.

All statements made by you in any of these materials will be treated by Avera Health Plans as representations, not warranties.

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

Avera Health Plans offers language assistance if you need information in a requested language. Interpretation services are available in over 100 different languages to help you receive information about your benefits or how to access medical services. This service is available by calling Avera Health Plans Service Center at 605-322-4545 or toll-free at 1-888-322-2115. A Customer Care Representative is available to assist you between 8 a.m. and 5 p.m. CT, Monday through Friday.

If members are hearing impaired, TDD/TTY services are available by calling 711 or 1-800-877-1113 from outside South Dakota. Request the Relay staff connect you to our Service Center at 605-322-4545.

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 **AveraHealthPlans.com** and click Member Login. If you are a first time user, click on Sign-Up to complete the member registration. After you enter your username and password, you will have access to view secure and confidential information regarding your health plan. You will also have access to the following:

- Provider directory – search for participating providers by name, city and state or by a specialty
- Claims and eligibility information
- Year-to-date deductible balances
- Summary of Benefits and Coverage
- Preventive resources and links for a healthier lifestyle
- Prescription drug formulary and lists of approved medications
- MemberView Newsletters
- AveraNow – your personal health and wellness program
- Forms and helpful links to understand your benefits
- Rights and privacy information

Visit Our Mobile App

Our Mobile App allows you access to your claims, pharmacy information and more on your smart phone. To download, search for MyHealthPlan. Your username and password is the same as you use to log in to your member portal.

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).
- Pay special attention to the section, What Is Covered and Not Covered.

For the purposes of this document:

- **You and Your** means you and your family members eligible under this Avera *MyPlan* Individual Health Benefits Policy.
- **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:

1. Participating providers is a negotiated contract amount,
2. 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.

Avera *MyPlan* Individual Health Benefits Policy means this contract, your application, the Summary of Benefits and Coverage, your identification card, and attachments that outline your benefits under this Policy.

Benefit Management Program. In certain situations you may qualify for an individualized Benefit Management Program. This individualized 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 alternative benefits. The Benefit Management Program may also include enhanced access to participating providers for covered benefits and other services designed to enhance your health.

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

Calendar Year means January 1 through December 31.

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

Clinical Trials is a biomedical or health-related research study in human beings which follows a defined protocol. In interventional studies, research subjects are assigned to a treatment or

intervention by the investigator. In observational studies individuals are observed and outcomes are measured by investigators.

Covered Health Services means medical diagnostic tests, treatments and supplies that are medically necessary and are listed as covered health services in this Avera *MyPlan* Individual Health Benefits Policy.

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.

Continuity of Care allows a member in "active treatment" to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost sharing rates. Active treatment is defined as:

1) An ongoing course of treatment for life-threatening condition;
2) An ongoing course of treatment for a serious acute condition;
3) The second or third trimester of pregnancy; or
4) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

A life-threatening condition is one where likelihood of death is probable unless the course of the disease or condition is interrupted; a serious acute condition is one requiring complex on-going care which the covered person is currently receiving, such as chemotherapy, post-operative visits, or radiation therapy. An ongoing course of treatment would include treatments for mental health and substance use disorders that fall within the proposed definition outlined above.

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 Parent means the parent awarded custody of a child by a court decree. If there is no court decree, the custodial parent is 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 policyholder.

Dependent Child means:

- The policyholder's biological child,
- A child lawfully adopted by the policyholder or in the process of being adopted, from the date of placement,
- A stepchild of the policyholder or
- A child for whom the policyholder 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.

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

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

Drug Tier A drug tier is a group of different drugs. The plan groups the drugs by price and each group or tier may require a different co-pay.

Effective Date means the date your coverage under this Policy began.

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 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:

1. 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,
2. In the case of a behavioral condition, placing the health of the individual or others in serious jeopardy,
3. Serious impairment to bodily function,
4. Serious dysfunction or disfigurement of any bodily organ or part,
5. Death or
6. Left untreated or unattended until regular office hours would result in hospitalization or medical disability.

Essential Health Benefits are benefits that 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 dental and vision care.

Generic Drug a drug that has the same active ingredients as its brand-name counterpart, and has been approved by the Food and Drug Administration (FDA) as being interchangeable with the brand-name drug as approved by your provider.

Habilitative Services are health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Health Care Provider is a health care professional.

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.

Hospice Services provide 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.

Hospitalization means an admission as an inpatient in a hospital.

In-Network is the highest level of benefits provided when covered services are received:

1. From a Participating Provider within the Avera Health Plans Service Area or
2. From a Participating Provider outside the Avera Health Plans Service Area if:
    a. A Participating Provider has recommended a referral and

   b. We have authorized the referral to a Participating Provider outside the service area or
   c. We have authorized the referral from a Participating Provider to a Non-Participating Provider
3. In an emergency or urgent care situation or
4. When the Member does not have appropriate access to 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:

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

Medically Necessary means health services which have been determined by our medical management 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 or improving 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 policy.

Non-Participating Provider means a physician, health care professional, health care facility, or pharmacy licensed, certified or accredited as required by state law. Some health services are not covered if they are received from a non-participating provider.

Out-of-Network is the lowest level of benefits when covered services are received:

1. From a Non-Participating Provider or
2. When we have not authorized a referral to Non-Participating Provider or
3. For non-emergency or non-urgent situations or
4. From a Participating Provider outside our service area when the member is traveling outside of our service area for purpose of receiving such services and
    a. Participating Provider has not recommended referral and
    b. We have not authorized a referral to Participating Provider outside of plan service area

Participating Provider a physician, health care professional, health care facility, or pharmacy licensed, certified or accredited as required by state law that have signed a contract with us to provide health services to members.

Physician means a doctor of medicine (MD), osteopathy (DO), podiatry (DPM) or chiropractic (DC).

Policy means the benefit program offered to you as an eligible individual policyholder.

Policy Year is a 12-month period of time that begins January 1 and ends December 31.

Policyholder means the individual that holds ownership of the insurance policy. A policyholder is also a member.

Premium means the monthly amount paid to us for your coverage under this Avera *MyPlan* Individual Health Benefits Policy.

Prescription Drugs are drugs and medications, products or devices that are approved by the Food and Drug Administration, are available by a prescription only (according to state and federal law), are considered self-administered and include compounded products prescribed by a licensed health care provider.

Primary Care Physician (PCP) 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

Prosthetic Devices are external devices used for artificial substitutes to replace a missing natural part of the body or devices to aid or restore the performance of a natural function.

Provider means a physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), health care professional or health care facility licensed, certified or accredited as required by state law.

Rehabilitation Services are health care services that help a person keep, get back or improve skills and functioning for daily living that have been lost or impaired because a person was sick, hurt or disabled. These services may include physical and occupational therapy, speech-language pathology and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

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

Routine Care for Clinical Trials is any diagnostic, surveillance, therapeutic labs, scans or treatments that would be done if the member was not enrolled in a clinical trial.

Self-Administered Drug is a drug that at least 50% of the members that take the drug can administer the drug to him or herself safely and effectively. Self-administered drugs are covered on the prescription benefit only. The list of self-administered injectable drugs can be found at **AveraHealthPlans.com** under Pharmacy Benefits. If the drug is not self-administered and a covered benefit, this would be covered under medical benefit.

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 provider who has a specific practice of medical care other than primary care. A specialist can also include a behavioral health care provider.

Specialty Drugs treat complex conditions such as hepatitis C, multiple sclerosis, cancer and rheumatoid arthritis.

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

State means the state of South Dakota.

Summary of Benefits and Coverage is a document that provides an overview of what you pay under your benefit plan for some of your covered health services; however, does not include all requirements or qualifications of each benefit.

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

Urgent Care means a situation, illness or injury which is less severe than an Emergency Condition but requires prompt medical attention within twenty-four hours.

We, Us and **Our** refers to Avera Health Plans.

You and **Your** means you and your family members eligible under this Avera *MyPlan* Individual Health Benefits Policy.

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:

- Receive information about your plan, participating providers, other health care professionals providing care and member rights and responsibilities.
- Be treated with respect and recognition of dignity and right to privacy.
- Have an open discussion and 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, medical necessity and associated risks regardless of the cost or benefit coverage.
- Voice and discuss complaints or appeals about the organization or the care of its providers.
- Make recommendations regarding our Member Rights and Responsibilities policy.
- Not be discriminated against because of age, gender, cultural background, educational or economic status, religious or sexual orientation or mental or physical disability.
- Not have genetic information used to determine eligibility, coverage, underwriting or premiums.
- Timely, proper medical care without discrimination of any kind, regardless of health status or condition.
- Receive advice or assistance in a prompt, courteous and responsible manner.
- 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. 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.
- Be notified 60 days in advance of the effective date of any material modification including changes in preventive benefits.

- Receive coverage without limitations or exclusions based on pre-existing conditions.

You have the responsibility to:

- Supply information (to the extent possible) that the organization and its practitioners and providers need in order to provide care.
- Follow your provider's instructions about your health care. Participate with your providers in making decisions about your health care.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.
- 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. 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. 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.
- If you have other health care coverage, make sure all of your providers, including pharmacies for prescription drugs, know that you are covered by more than one plan.
- Ensure your provider has obtained required preauthorization.

What I Pay for Medical Services

What Are the Levels of Coverage?

There are two levels of coverage available:

In-network coverage is the highest level of benefits provided when covered services are received:

1. From a Participating Provider within the Avera Health Plans Service Area or
2. From a Participating Provider outside the Avera Health Plans Service Area if:
    a. A Participating Provider has recommended a referral and
    b. We have authorized the referral to a Participating Provider outside the service area or
    c. We have authorized the referral from a Participating Provider to a Non-Participating Provider
3. In an emergency or urgent care situation or
4. When the Member does not have appropriate access to Participating Provider.

Out-of-network coverage is the lowest level of benefits when covered services are received:

1. From a Non-Participating Provider or
2. When we have not authorized a referral to Non-Participating Provider or
3. For non-emergency or non-urgent situations or
4. From a Participating Provider outside our service area when the member is traveling outside of our service area for purpose of receiving such services and
    a. Participating Provider has not recommended referral and
    b. We have not authorized a referral to Participating Provider outside of plan service area
5. Some health services are not covered if they are received from a non-participating provider. Please refer to your Summary of Benefits and Coverage and the What is Covered and Not Covered Section in this document.

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 in your Summary of Benefits and Coverage.

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 Summary of Benefits and Coverage.

You may have a separate in-network and out-of-network deductible. After you pay the deductible, we begin to pay benefits for your covered health services as listed in your Summary of Benefits and Coverage.

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

What Is Coinsurance?

Coinsurance is the percentage of costs of a covered health care service you pay (20%, for example) after you have paid your deductible. Refer to your Summary of Benefits and Coverage 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 may have a separate in-network and out-of-network deductible and coinsurance. 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.

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 apply toward your out-of-pocket limit. Refer to your Summary of Benefits and Coverage 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 limit?

The out-of-pocket limit is the total amount of medical and pharmacy deductible, coinsurance and co-pays you pay out of your pocket for covered health services during the year. Refer to your Summary of Benefits and Coverage for your specific out-of-pocket limit. There is an out-of-pocket limit for each member covered by this Policy. After you have reached this limit, we pay 100% of our allowed amount for covered health services from participating providers for the remainder of the policy year.

Do I Have a Lifetime Dollar Limit?

No, you do not have an annual or lifetime dollar limit. Essential health benefits provided within this policy are not subject to an annual or lifetime dollar limit.

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.

If you need primary care, specialty care, behavioral health care services or hospital services, review our online provider directory at **AveraHealthPlans.com**. If you do not have online access, call our Service Center and speak to one of our Customer Care Representatives for a full list of participating providers, including specialists and behavioral health care providers.

Avera Health Plans uses guidelines to make sure members have appropriate access to primary specialty and behavioral health care providers.

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 Medical 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:

- Participating providers go through a credentialing process in accordance with The Joint Commission and NCQA Standards to ensure safe clinical practices. Only providers meeting our credentialing criteria are accepted into the Avera Health Plans network.
- 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.

FOR MORE INFORMATION

Please visit our website at AveraHealthPlans.com and log in with your username and password and to view the most up-to-date list of your 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 limit.
- All non-participating provider bills 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. Your coinsurance for health services from a participating provider is 20% and your coinsurance for non-participating providers is 50%.

	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	$450 ($900 x 50% = $450)	$550 ($1,000 - $450 = $550)

When to Call Before Receiving Medical Services

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

We do not compensate individuals who conduct review for issuing denials of coverage and will not provide rewards for medical management decision-makers to encourage denials of appropriate coverage. Incentive to underutilize is not rewarded.

What Is Preauthorization?

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

What Medical Services Require Preauthorization?

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

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

Your provider must submit medical records for review to Medical Management Department.

What Is the Preauthorization Process?

- Your provider will need to obtain preauthorization for certain procedures and services. Additional information can be found our website at **AveraHealthPlans.com**.
- You also need to obtain preauthorization if you are requesting in-network benefits for health services from a non-participating provider.
- We will review the information for medical necessity 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 authorized (for example, office visit only or office visit and lab tests). Please read this letter carefully so you know what services have been authorized
    - If your request for preauthorization 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.
- For further assistance or if you have any questions concerning preauthorization, call the Medical Management Department toll free number 1-888-605-1331.

What I Pay for Prescriptions

How Much Will I Pay for Prescriptions?

The amount you pay for your prescription depends on the drug's tier level and the benefit level shown in your Summary of Benefits and Coverage.

If you use an in-network pharmacy and do not use your member ID card, you will pay the co-pay plus the cost difference between the cash price and the discounted price. The co-pay amount will apply to your out-of-pocket limit. Any additional charges will not apply to your out-of-pocket limit.

If you use an out-of-network pharmacy, you will pay the full cost of the drug and it will not apply to your out-of-pocket limit.

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. The co-pay amount will apply to your out-of-pocket limit. Any additional charges will not apply to your out-of-pocket limit. We do not allow for reductions on prescription co-pays.

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 at **AveraHealthPlans.com** 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 three 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.

When to Call Before Receiving a Prescription

You need to have your health care provider call for preauthorization for certain medications. If you do not obtain a preauthorization, your prescription will not be covered.

What Is Preauthorization?

Preauthorization means the notification process when specific prescription medications are approved prior to being received. Preauthorization does not guarantee benefits. Your benefits are subject to all conditions of this Policy.

What Drugs Require Preauthorization?

To review the most current list of medications needing preauthorization, visit us online at **AveraHealthPlans.com**

What Is the Preauthorization Process?

To receive preauthorization:

- Ask your health care provider to obtain preauthorization before prescribing the medication, or
- When you present your prescription at a participating pharmacy, the pharmacist will contact your health care provider to notify them of the preauthorization requirement.

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

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.

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

Are there Limitations to Specialty Medications?

Yes, please visit us online at **AveraHealthPlans.com** for a listing of limitations.

How Do I Obtain Early Refill Request?

We may allow for early refills if traveling for an extended period of time; however; we will not exceed a 90-day supply per calendar year. Early refill requests can be obtained from the pharmacy benefit manager by calling the phone number on your ID card.

What if my Prescription is Lost, Stolen, or Damaged?

Early refill requests due to your prescription being lost, stolen or taken inappropriately will not be approved.

What if my Plan does not cover a Prescription I Need?

You can request a formulary exception if you believe the prescription you take should be covered because other treatment options on the drug formulary do not work for you. To request a formulary

exception, you or your health care provider must provide written documentation to include the following:

- Why no other prescription on the drug formulary will work as well as the requested medication,
- What other prescriptions have been tried and how you responded to these medications
- Medical documentation to support medical necessity.

We will review the information and when a decision has been made, you and your health care provider will receive a letter that states the decision. If a formulary exception is approved, the non-preferred co-pay (for the applicable drug type) will be applied. The prescription must be a covered benefit on your plan. Formulary exceptions do not include reductions on prescription co-pays. Formulary exceptions can be requested by you or your provider.

What is Covered and Not Covered?

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

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

- Follow our preauthorization requirements (if applicable) and,
- Be medically necessary.

If a service or supply is not listed, do not assume it is a covered benefit.

Abortion

Covered: 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 only for the purpose of terminating a pregnancy.

Acupuncture and Other Alternative Treatments

Not Covered: Examples include acupuncture, acupressure, massage therapy, naturopathy, homeopathy, holistic medicine or therapeutic touch.

Alcohol Dependency Treatment Services

Covered: Inpatient, outpatient and partial-day programs from a licensed health care provider.

Not Covered: On site living for outpatient residential day treatment.

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 medically necessary and approved by us.

Anesthesia Services

Covered.

Anesthesia for Dental Care

Covered: General anesthesia is a covered dental service for a member who is under age 14, is severely disabled or has a medical condition that puts such member at serious risk as determined by a licensed physician.

Autism Therapy

Covered: Autism treatment, including Applied Behavioral Analysis (ABA) Therapy from a licensed or certified health care provider. Preauthorization required.

Not Covered: ABA Therapy from a provider not licensed or certified in ABA Therapy.

Biofeedback

Covered: Biofeedback is limited to the following conditions: anorectal biofeedback and biofeedback used in the overall treatment plan for migraine and tension-type headaches. Preauthorization required.

Not Covered: Biofeedback for other indications.

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:

- Electric or manual breast pump
- Replacement tubing and breast shields
- Lactation consultation

Not Covered: Supplies and services such as:

- Pumps or supplies purchased from a retail or department store
- Bottles, breast milk storage bags and supplies
- Services and supplies from an out-of-network provider

Breast Reconstruction

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, and
- Nipple tattooing.

Not Covered:

- Replacement of a breast implant if the initial implant was used for cosmetic reasons.
- Reconstructive services deemed as cosmetic

B-12 Injections

Covered: Pernicious anemia only.

Care Received Outside of the United States

Covered:

- Emergency and urgent care services.

Not Covered: Items such as:

- Meals, lodging, airfare and other miscellaneous expenses.
- Health services if you travel outside the country for the sole purpose of seeking medical treatment

Cardiac Rehabilitation

Covered.

Not covered: Cardiac Rehabilitation Phase III

Casts, Splints, Braces, Crutches and Dressings

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

Chelation Therapy

Covered: For acute arsenic, gold, mercury or lead poisoning only.

Chemical Dependency Treatment Services

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

Not Covered: On site living for outpatient residential day treatment.

Chemotherapy/Radiation Therapy

Covered.

Chiropractic Services

Covered: Outpatient treatment related to the musculoskeletal system. For example, manipulations to treat musculoskeletal injury or disease.

Preauthorization is required after a certain number of visits are met. Please see your Summary of Benefits and Coverage for limitations and exceptions.

Not Covered: Items such as massage therapy

Clinical Trials

Covered: Routine care. Preauthorization is required. All applicable plan limitations for coverage of out-of-network care will apply to routine costs in clinical trials

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

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, patient education and counseling for females.

Not Covered:
Items such as:

- Condoms
- Drugs for abortion
- Male contraceptive methods are not covered.

Continuity of Care

Covered:

- Acute or certain chronic conditions up to 90 days from the effective date with this policy.
- Members in the second or third trimester of pregnancy are allowed continued access to the provider through the postpartum period.

NOTE: Preauthorization is required.

Cosmetic Services

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

- Improve physical appearance 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,
- Prevent or treat mental illnesses through a change in bodily form, or
- Removal of skin tags when deemed not medically necessary

Counseling Services

Covered: Counseling for mental health illnesses. Family counseling for children under the age of 18; child has to be present at all sessions.

Not Covered: Items such as:

- Marriage counseling,
- Family counseling for ages 18 and older,

- Bereavement counseling,
- Pastoral counseling,
- Financial counseling, and
- Legal counseling.

Custodial Care

Not Covered: Care such as:

- 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 capped and filled.
- Impacted teeth removal (surgical) allowed only when you have a medical condition (such as hemophilia) that requires hospitalization.
- Facial bone fracture reduction.
- Incisions of accessory sinus, mouth, salivary glands or ducts.
- Jaw dislocation manipulation.
- Orthodontic services required for surgical management of cleft palate.
- Treatment of abnormal changes in the mouth due to injury or disease.

Not Covered: Services and supplies such as:

- Dental X-rays,
- Ridge augmentation,
- Implantology,
- Preventive vestivuloplasty services and
- Impacted teeth removal (unless noted above)

NOTE: See also Anesthesia for Dental Care.

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.

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.

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, no more than 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 Equipment covered through your Medical Benefit

Covered: Equipment such as:

- Insulin pumps,
- Insulin pump supplies, and
- Two pairs of diabetic shoes.

NOTE: See also Durable Medical Equipment.

Diabetes Supplies covered through your Pharmacy Benefit

Covered: Equipment and supplies such as:

- Blood glucose monitors,
- Blood glucose test strips,
- Urine test strips,
- Insulin,
- Injection aids,

- Lancets and lancet devices,
- Syringes,
- Oral agents for controlling blood sugars,
- Glucose agents,
- Glucagon kits,
- Insulin measurement and administration aids for the visually impaired.

Not Covered: Items such as food items and nonprescription drugs

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. We will determine whether an item is categorized as purchase, rent to purchase, or rental only, and the length of rental for both rent to purchase and rental only items. These categories may not align with CMS (Medicare) determinations. Coverage costs should not exceed the lesser of the amount charged or the maximum allowable fee. Limitations per policy may apply.

Covered:
Durable medical equipment must be:

- Prescribed by a licensed health care provider,
- Medically necessary 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 pump supplies.
- Enteral pump, supplies and equipment

NOTE: Preauthorization is required for certain items. See Durable Medical Equipment preauthorization list.

Not Covered: Items such as:

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

- Items used primarily for educational purposes,
- Duplicate or similar items,
- Household equipment which primarily have customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs or whirlpools.

Education Programs and Tutoring Services

Not Covered: Services such as family planning or other education programs related to a disease or illness.

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.

FOR MORE INFORMATION

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

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: 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 or Cytogenetic Studies

Covered: Testing is covered when the test results will determine a course of treatment or care. Preauthorization is required.

Not Covered: Testing such as:

- Family planning or
- Informational purposes.

Hearing Services

Covered: Professional audiology services not related to an illness or injury. Hearing services include coverage for medically necessary physician services appropriate for the treatment of hearing impairment to a person under the age of 19. This includes professional services provided by a licensed audiologist. Benefits are subject to the same dollar limits, deductibles, coinsurance and other limitations provided for other covered medical benefits associated with this health insurance policy.

Preauthorization is needed for cochlear implants.

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

Hemodialysis

Covered: Until the patient qualifies for federally funded services under end stage renal disease (ESRD). Services include equipment, training and medical supplies.

Home Health Services

Covered: The following services are covered if ordered by a licensed health care provider:

- 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 and select drug therapies.

Not Covered: Care such as custodial or maintenance care.

Hospice Services

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

- In patient 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 licensed health care provider's order and
- Psychological and dietary counseling.
- Respite Care

- Respite care is limited to 15 days inpatient and 15 days outpatient per lifetime. Respite care must be used in no more than five (5) days at a time.

Not Covered: Therapy that would treat the terminal condition while in hospice.

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, medications prescribed or ordered by a licensed health care provider and administered during hospitalization and
- Inpatient rehabilitation services.

NOTE: Preauthorization is required for inpatient services.

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 surgery centers, residential or transitional living centers, or similar facilities.

Not Covered: Personal hygiene and convenience items such as toothbrush, toothpaste, slippers or facial tissue (for example, Kleenex®.)

Hypnotism, Hypnotic Anesthesia and Sleep Therapy

Not Covered.

Inhalation Therapy

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

NOTE: See Durable Medical Equipment (DME) for inhalation equipment benefits.

Laboratory and X-ray Services

Covered. Certain imaging requires preauthorization.

Long-Term Care

Not 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. If complications or extended stay do occur, please contact our Service Center.
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.

NOTE: Hours are calculated based on the birth of the newborn child.

Upon the recommendation of the mother's health care provider, 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. Coverage only applies if surrogate is an Avera Health Plans member.

Medical Supplies

Covered: Supplies such as:

- Colostomy supplies,
- Catheters and
- Infusion sets for drug therapy

Not Covered: Any medical supplies that can be purchased without a prescription

Mental Health Services

Covered: The diagnosis and treatment from a licensed health care 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

Tip

Be sure to check our preauthorization list to ensure your specific procedure(s) does not need to be authorized by us prior to service.

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,
- 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.

Not Covered: On site living for outpatient residential day treatment.

Newborn Care

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

Nursing Home

Not Covered. See also Skilled Nursing Facility Services.

Nutrition

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
- Parenteral and Enteral Nutrition if deemed medically necessary.

Not Covered: Products such as:

- Food supplements,
- Nutrients,
- Infant and adult formulas unless described as **Covered** above.

Orthognathic Surgery

Covered: Only for abnormality causing functional impairment.

Not Covered: Surgery for cosmetic purposes

Orthotic and Orthopedic Devices

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

Not Covered: Devices such as:

- 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 Products and 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 and other Licensed Health Care Services

Covered: Services such as:

- Office visits,
- Inpatient visits,
- Injectable (non self-administered) medications and
- Surgical care.

Prescription Drugs

Covered: Prescription drugs that are prescribed by a licensed health care provider and purchased at a participating pharmacy.

Not Covered:

- Prescriptions that are received without charge under a federal, state or local program,
- Prescriptions used for cosmetic purposes (like baldness),
- Prescriptions provided by a hospital that are not used during the hospital stay,
- Prescriptions in convenience packaging,
- Prescriptions that are lost, stolen, damaged or used inappropriately,
- Prescriptions refills that are more than one year old,
- Prescriptions that are over the day's supply or quantity limit,
- Over-the-Counter drugs unless it is part of a program we offer,

ALERT

Preauthorization and quantity limits may apply to specific prescription drugs.

- Prescriptions that are therapeutically the same as an over-the-counter drug,
- Investigational, experimental or unproven drugs or drug usage,
- Prescriptions considered homeopathic, dietary supplement or nutraceutical in nature including combinations with a prescription drug,
- Prescriptions used to treat infertility or to enhance fertility,
- Prescriptions used for weight-loss,
- Prescriptions that cannot be self-administered (these may be covered under the medical benefit),
- Serums, toxoids or vaccines except flu, pneumococcal and shingles,
- Vitamins, except for vitamins A, D, E, K and prenatal and
- Fluoride, except pediatric formulations.

Preventive Care Services

Covered: Items or services including, but not limited to:

- Items or services with an "A" or "B" rating in the current recommendations of the United States Preventive Services Task Force (USPSTF):
- Immunizations as recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;
- Preventive care and screenings for infants, children and adolescents provided for in the guidelines supported by the Health Resources and Services Administration (HRSA); and
- Preventive care and screenings for women provided for in guidelines supported by the HRSA.

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 **AveraHealthPlans.com**, log in and click on my benefits for a complete list of covered preventive care services as recommended by the United States Preventive Services Task Force, the Health Resources and Services Administration and the Centers for Disease Control.

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

Covered. Preauthorization is required for items included on the Durable Medical Equipment List.

Not Covered: Devices such as:

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

Reconstructive Services

Covered: Services are covered if the service is used:

- 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: Services such as dental services and gender identity disorder

NOTE: Also see cosmetic services, breast reconstruction and orthognathic surgery

Self-Help Programs

Not Covered. Programs such as:

- 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 a 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.

Not Covered: Skilled nursing and nursing home facility services 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

Covered:

- Physician and counseling treatment.
- Nicotine items such as gum, patches and lozenges if prescribed by a licensed health care provider.
- Chantix

Not Covered: Nicotine inhalers and nasal spray

Sterilization Services

Covered.

Not Covered: Reversal of sterilization procedures

Surgery Center Services (Ambulatory Surgery Center)

Covered: Services furnished in connection with a surgical procedure performed in a licensed or certified ambulatory surgical center.

Surgery Services

Covered.

TMJ (Temporomandibular Joint Disorder) and Craniomandibular Disorder

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. Preauthorization is required.

Therapy (Habilitative)

Covered: Therapy and other services for people with congenital disorders, developmental delays or disabilities in a variety of inpatient and/or outpatient settings. Services may include:

- Physical therapy
- Occupational therapy
- Speech therapy

Preauthorization is required after a certain number of visits are met.

Not Covered: Therapy services primarily for job training and related to general conditioning of the patient.

Therapy (Rehabilitative)

Covered: Therapy and other services that help a person maintain or improve skills and functioning for daily living that have been lost or impaired due to sickness or injury. Services may include:

- Physical therapy
- Occupational therapy
- Psychiatric rehabilitation services

- Speech therapy

These outpatient rehabilitation therapies improve physical functioning and provide significant improvement within two months. These therapies can be offered in a variety of inpatient and/or outpatient settings.

Preauthorization is required after a certain number of visits are met.

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.

Transgender Services

Covered: Preauthorization is required for certain services.

Not Covered: See Breast Reconstruction, Cosmetic Services, and Reconstructive Services.

Transplant Services

Covered: Services include evaluation, donor search, transplant, follow-up care and immunosuppressive drugs (subject to limitations listed below).

- Preauthorization is required for all evaluations and transplant services.
- 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 specific to 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.

Urgent Care Services

Covered.

Vision Services - Adult Coverage

Covered:

- For Aphakia patients – corneal transplants and prosthetic devices
- 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.

Vision Services – Pediatric Coverage

Vision services are provided by VSP (VSP.com). Please see the Pediatric Vision Addendum for benefit details.

Covered: VSP services

Not covered:

- Vision therapy

Weight Reduction

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

- You must be at least 18 years of age or older,
- One (1) per lifetime, and
- Preauthorization is required.

Not Covered: Products and services such as:

- 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.

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 and,
   - Excise and sales taxes.

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 licensed health care provider who is a member of your immediate family by blood, marriage or adoption that normally resides in the member's home. 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,
- From an act of declared or undeclared war or armed aggression 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. Work-related injury or illness for which benefits are paid by a workers' compensation policy or similar law.

15. Services such as, learning disabilities, Cognitive impairment, marital family, educational, vocational, recreational or other counseling services, Milieu therapy, sensitivity training, eating disorders, conduct disorders are not covered.

When I Have Other Medical Coverage

What Is Coordination of Benefits?

TIP

We follow South Dakota Coordination of Benefits Rules.

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 choose to have family coverage or you choose to have an Individual Policy as well as a policy through your employer.

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.

How Does Coordination of Benefits Work?

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.

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.

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 policyholder 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.

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?

1. 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.)

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

3. If you are covered as a policyholder on two plans, the following rules apply:

   - **COBRA**. The plan covering you as an employee, policyholder or retiree will pay before COBRA or a state continuation plan.
   - **Medicare**. If you are enrolled in Medicare coverage, you are not eligible for coverage under this Plan.
   - **Longer or Shorter Length of Coverage**. The plan that has covered you as a policyholder the longest pays first.

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.

ALERT

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

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

1. If a dependent child has coverage as a policyholder, the child's coverage pays before the parent's.

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

3. 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.

4. 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.

5. 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.

If the rules above don't determine who pays first, the plan that has covered you as a dependent the longest pays first.

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 policy 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.

When I Have a Work-Related Injury

State law requires 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.

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 **AveraHealthPlans.com** 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 must use the most current claim form available. Avera Health Plans will only accept the following completed claim forms listed below. All other forms submitted will be returned to your provider.

- Individual providers use claim form CMS 1500.
- Hospitals/facilities use claim form UB-04.
- Dental use current ADA Dental Claim Form.

FOR MORE INFORMATION

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

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 (proof of loss) from a non-participating provider within 12 months of the date you received health care services. We will not pay claims (proof of loss) 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.

Complaints and Appeals Procedures

We strive to provide quality service to all our members. There may be a time you are not fully satisfied with the medical necessity decision, administration, claims practice or service provided. As a member of Avera Health Plans, you have the right to file a grievance. There are two types of grievances; a complaint which is an expression of dissatisfaction and an appeal which is a request to change a previous decision. In compliance with the state of South Dakota, we have provided you with the following complaint and appeals procedure.

If you are not satisfied with a decision of ours that affects your coverage, quality of care you or service received from us, have a complaint or want to contest the disposition of a claim, you may direct your grievance to our Service Center at 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105-6538 or by calling 605-322-4545 or toll-free at 1-888-322-2115 without initiating a formal appeal. You will receive acknowledgement within three (3) business days if receipt of the complaint. A written response will be sent to you within 30 business days of the complaint.

If you are dissatisfied with a complaint resolution, you can file a formal appeal by submitting a written notice indicating you are filing an appeal. Below is the process on how to proceed with an appeal.

When Can I Submit an Appeal?

You or the person you authorize in writing to represent you (your authorized representative) may request a first-level review by submitting a written appeal or by completing an appeal form. You must submit the appeal 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 appeal.)

FOR MORE INFORMATION

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

Once your appeal 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)

How Do I Submit A Complaint or Appeal?

Complaint and Appeal forms are available from our Service Center or on our website at **AveraHealthPlans.com**. You may send a complaint, an appeal or written request to:

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

TIP

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

What If I Have an Appeal That Is Urgent?

If you have an urgent appeal, 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 appeal is 72 hours. Your provider must call Medical Management at 1-888-605-1331 to request an expedited appeal review. The phone number is also listed on the back of your member ID card. You do not need to submit your urgent appeal 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 member fails to provide sufficient information to determine if a service is covered, we will notify the member within 24 hours to obtain the necessary information and will include the specific information necessary to complete the claim. You will have at least 48 hours to provide the specified information. Once the information is obtained, a determination will be made within 48 hours or remaining hours (whichever is earlier).

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

What Happens After I Submit the Appeal?

When we receive your appeal, we will send you or your authorized representative a letter within three (3) calendar 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 appeal for consideration during the review. You will be provided copies of all relevant documentation that is not confidential or privileged used to make the initial decision, free of charge, upon request.

Who Reviews the Appeal?

Your first-level appeal 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 appeal will be reviewed by a physician of the appropriate specialty who understands the appeal 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 appeal,
- 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,
- 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 Appeal Review Decision?

If you are not satisfied with the first-level appeal 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 appeal 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 Appeal?

In order to be eligible, you must file the appeal 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 **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
124 S. Euclid Ave., 2nd Floor
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 appeal,
- 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 Appeal Review Decisions?

Type of Appeal	Level of Appeal Review	Days to Receive Decision	Additional Information

Prospective	First-level (internal)	30 calendar 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 calendar 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/appeal 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 calendar 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 Appeals 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 if you are:

1. A resident of the state of South Dakota, (you must have a street address),

2. You are a United States Citizen or lawfully present in the United States; and

3. Not enrolled in Medicare coverage.

You are eligible for Coverage in a Catastrophic Plan by meeting the requirements above and one of the following:

1. You and your family are under the age of 30; or

2. You have received a hardship waiver from the Marketplace at healthcare.gov

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. If your dependent child turns 26 during the policy year, the dependent child will be covered through December 31 or
- If your plan is issued directly with Avera Health Plans, your dependent is eligible if 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.

When Can I Enroll?

You have two opportunities to enroll for health care coverage.

Opportunities to Enroll	When To Enroll	Effective Date
Annual Open Enrollment Period	Annual open enrollment timeframe is determined by the Federal government. Please refer to healthcare.gov for specific dates.	If selection is within the first 15 days of the month, coverage will start at the 1st of the following month. On or after the 16th of the month, coverage will start of the month after the next.
Special Enrollment Period (SEP) See list of life event examples that may qualify you for a SEP.	• Getting married/divorced • Loss of other creditable coverage • Adding dependent(s) • Court-ordered coverage • Federal government SEP(s)	See the following conditions for effective dates.

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

If your plan is issue directly with Avera Health Plans and 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 adult 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 Make Changes to My Plan?

You can make changes during any open enrollment period. During this time, all eligible applicants are allowed to enroll and you are also allowed to change plans.

Plan Changes during Special Enrollment

You have 60 days to enroll or make a change to your health plan from the date of a qualifying event listed below.

- Termination of individual employer coverage other than by reason of gross misconduct, or loss of coverage due to reduction of hours of the covered employees spouse,
- Death of a covered individual
- Divorce or legal separation,
- Individual becoming entitled to benefits under XV11 of Social Security Act,
- Dependent child ceasing to be dependent child,
- Proceeding in a case under title 11, United States Code, commencing on or after July 1, 1986 with respect to the employer from whose employment the covered individual retired at any time,
- Individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption,
- Individual who was not previously a citizen, national, or lawfully present individual gains such status or,
- Individual gains access to non-grandfathered health plans as a result of a permanent move.

Special Enrollment Conditions

A special enrollment period will apply if your 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- if the other coverage was under a COBRA or state continuation provision, due to exhaustion of the continuation.

If your request for enrollment is made within 60 days after the other coverage terminates, your effective date of coverage will be no later than be the first of the month following plan selection.

If you are enrolling due to loss of prior coverage, you will need to provide a document from your previous health insurance company that shows the beginning and ending dates of your health insurance coverage with them. Send a copy of the document to us at the following address or fax it to us at 605-322-4689.

ALERT

If adding a newborn to your policy, you must enroll the newborn within 90 days of the date of birth. This will ensure that the newborn's effective date of coverage is the date of birth.

Avera Health Plans
Attn: Enrollment
3816 S Elmwood Ave., Suite 100
Sioux Falls, SD 57106

If you don't have documentation of prior coverage please contact your previous health insurance company to obtain one.

New 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 90 days after the date of the marriage, birth, adoption or placement for adoption.

Event	You Must:	The Effective Date is:	Amount of Time to Submit Application:
Marriage	Complete an application form for a current plan that is being offered.	1st of the month following plan selection	60 days from the date of marriage
Dependent child's birth, adoption or placement for adoption.	Complete an application for enrollment	Date of Birth, adoption or placement for adoption	60 days from the date of birth, adoption or placement for adoption

*****If you do not notify us within 60 days after marriage, birth, adoption, or placement for adoption, you will need to enroll during the annual open enrollment period.

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.

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.

When Does Coverage Begin?

Your policy becomes effective at 12:00 a.m. (midnight) CT, on the date you become effective.

When Is My Premium Payment Due?

Your Policy will remain in force and will automatically renew each month as long as we receive your premium payment. Payments are due by the first of each month.

The entire premium amount due must be paid in full for your initial payment. If you are in a grace period, partial payments will not satisfy your obligation or forward your due date. The balance must be paid in full prior to the end of the grace period. Partial payments that do not satisfy the full amount due by the end of a grace period will be returned to you and your policy will be cancelled. Any overpayments will be applied towards future premium billing. If premium payment is not received by the due date, the Policy will default to the grace period.

When Is My Grace Period?

If you enrolled through the Health Insurance Marketplace, you may have qualified to receive a new kind of tax credit called an Advanced Premium Tax Credit. This tax credit impacts your grace period.

With Advance Premium Tax Credits	**Without Advance Premium Tax Credits**
A grace period of 90 days will be granted for the non-payment of each premium after application for coverage and payment of one full month premium. Your Policy will remain in force; however, after the first 30 days of your grace period your medical and pharmacy claims processing will be suspended. Non-payment of all outstanding premiums during the 90- day grace period will result in termination of the policy back to the last day of the first month of the 90- day grace	A grace period of 30 days will be granted for the non-payment of each premium after application for coverage and payment of one full month of premium. Your Policy will remain in force; however, during the 30- day grace period your medical and pharmacy claims processing will be suspended. Non-payment by the end of the grace period will result in termination of the policy back to the last day of the month in which premium was paid.

Termination

When Does Coverage End?

Termination by You if Enrolled Directly With Us

If your plan was issued directly with Avera Health Plans, you may terminate coverage for yourself or any dependents by notifying us in writing. Your notification has to be received prior to the date of termination. Your policy will be terminated at the end of the month following receipt of the written notification. You will be responsible for any premiums through the date of termination.

If you terminate coverage for yourself or if you become deceased, your covered dependents are entitled to an Avera *MyPlan* Individual Health Benefits Policy. Covered dependents must complete a change form and select one of the plans that are currently being offered.

TIP

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

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.

If termination results in a refund of premium it will be sent the following month. For coverage lasting less than one month, the pro-rated premium amount will equal the premium paid for the month divided by the number of days in the month to determine the daily premium amount. You will be refunded the daily premium amount for each day you did not have coverage.

Termination by You if Enrolled Through Marketplace

If you enrolled in coverage through the Marketplace, it is necessary for you to contact the Marketplace directly to cancel coverage. The termination date is determined by the Marketplace and will be sent to us to process.

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 your termination date.

Reason	Description	Termination Date
Failure to Pay Required Payments	You fail to pay required payments by the due date.	Coverage will be terminated back to the last day for which premiums were received.
Fraud or Intentional Misrepresentations	You intentionally misrepresent or conceal 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.*

Reason	Description	Termination Date
Eligibility	You become ineligible for coverage based on eligibility guidelines.	We will notify you of your termination date.
--No longer a resident of the state of South Dakota or have lived outside of South Dakota for more than ninety(90) consecutive days	When you are no longer a resident of the state of South Dakota or have lived outside of South Dakota for more than ninety (90) consecutive days, you are no longer eligible for coverage with us. However, your covered dependents may be entitled to an Avera *MyPlan* Individual Health Benefits Policy if they remain a resident of the state of South Dakota. Covered dependents must complete a change form and select one of the plans that are currently being offered. Covered dependents must request coverage within 60 days following eligibility and submit payment of the appropriate premium.	End of the month of when we receive the termination notice.
--Enrolled in Medicare or Social Security Disability	* When you enroll in Medicare or Social Security Disability benefits, you are no longer eligible for coverage with us. However, your covered dependents are entitled to an Avera *MyPlan* Individual Health Benefits Policy with the existing coverage and no medical underwriting. Covered dependents must request coverage within 60 days following enrollment and submit payment of the appropriate premium.	

Reason	Description	Termination Date
Discontinue / Non-Renewal of Avera *MyPlan* Policies by Us	We decide to not renew any health benefit policies to any policyholders in South Dakota. We will notify you at least 90 days before coverage is discontinued.	at 90 days after you receive notice
We Stop Offering an Avera *MyPlan* Individual Health Insurance Policy	We stop offering an individual health insurance product in this market. We will notify you at least 90 days before coverage is terminated.	90 days after you receive notice

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. If the decision is in your favor, coverage will be reinstated with no break in coverage.

General Provisions

Contract

You will receive a copy of all documents that make up your contract (this Avera *MyPlan* Individual Health Benefits Policy, including benefit options, your application, the Summary of Benefits and Coverage, your identification card, and attachments). No change in this Policy is valid until approved by an executive officer of Avera Health Plans and unless such approval is endorsed or attached to this Policy. No insurance producer has authority to change this Policy or to waive any of its provisions. All statements made by you under this Avera *MyPlan* Individual Health Benefits Policy 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 Individualized 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 alternative benefits. The Benefit Management program may also include enhanced access to participating providers for covered benefits and other services designed to enhance your health.

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 Avera *MyPlan* Individual Health Benefits Policy;
- 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.

New Technology and How This Impacts You and Your Benefits

New technologies are developed constantly in health care. Avera Health Plans has a formal process to review and evaluate new technologies to assure the new technology is safe, has a positive effect on health outcomes and is used appropriately. A new technology may include:

- a new way to perform an existing procedure,
- a new device,
- a new use for a piece of equipment.

Requests to review a new technology may come from providers, members, agents or through Avera Health Plans' business operations.

We are responsible for the assessment of emerging and evolving medical technology, medical policy development and policy maintenance. A group of board-certified, clinically practicing physicians, including physicians from various medical specialties review the following:

- relevant clinical literature about the new technology,
- government regulatory body approval
- information about technology assessment services (i.e. Hayes, Inc., Agency for Healthcare Research and Quality (AHRQ))
- professional organization position statements, industry standards,

- provider opinions.

After clinical review, the new technology is evaluated by Avera Health Plans for inclusion as a covered benefit. Technology assessment decisions are published in the form of medical policies and are posted to our website for your providers to access and use in their practice. In addition, Avera Health Plans members may request a copy of a medical policy by contacting our Service Center at 1-888-322-2115. All existing medical policies are reviewed at least annually and updated accordingly.

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 policyholders 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 policyholders 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 **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 communicate 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.

• 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: (a) required by law; (b) agreed to by you; or, (c) 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) a family member, other relative, a close personal friend or any other person identified by you; or, (b) to 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: (a) what information you want to limit; (b) whether you want to limit use or disclosure or both; and, (c) 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 **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, **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 toll free 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.

Keep Your Plan Informed of Address

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

Pediatric Dental Coverage Addendum

If you are enrolled in this plan, you are entitled to the benefits described below.

Other requirements such as, but not limited to, in-network/out-of-network providers, work-related injury, claim filing, complaint procedures, right of recovery, eligibility and enrollment, coordination of benefits, termination, continuation provisions and other general provisions noted in the Individual Health Insurance Policy are applicable to this addendum unless otherwise noted below.

All benefits are subject to the definitions, limitations and exclusions listed and are payable only when deemed necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted dental protocols.

All exams, oral evaluations and treatments are combined under one limitation under the plan. Periodic oral exam, oral evaluations and comprehensive oral exam are combined and limited to one exam every 6 months (from the date services were last rendered). All services requiring more than one visit are payable once all visits are completed.

Eligibility

Coverage is provided for members up to age 19. If member turns 19 in the middle of a plan year, coverage is provided until the end of the month of their 19th birthday.

Orthodontic Waiting Period

There is a waiting period for orthodontic services. To meet this requirement, the member receiving orthodontia services must be enrolled in the same plan for an entire and continuous 24 month waiting period to receive orthodontic coverage in the same plan option. Any change in the plan option will result in the member having to satisfy a new 24 month waiting period, for that plan option, in order to be eligible for orthodontic services. Re-enrollment, after returning from another dental carrier plan, will require the member to satisfy a new 24 month orthodontia waiting period for the elected plan option.

Continuation of Coverage

Upon the termination of this plan, certain benefits will be continued to be paid for a 31 day period after the plan termination date, if before coverage ends, the provider:

- Prepared the abutment teeth for the completion of installation of prosthetic devices
- Made an impression
- Prepared tooth for cast restoration
- Provider opened pulp chamber and the device is installed or treatment is completed within 31 days of plan termination date

Identification Cards

You can use your member ID card; you do not need a separate card for dental services.

Where Can I Get Covered Care

You may choose any dental provider in the state when using benefits provided in this plan.

Do I Need an Authorization?

Predetermination is recommended for any treatment or services with an anticipated cost of $300 or more. Predetermination is required to such services (but not limited to) orthodontia and periodontal services, crowns, bridges, inlays/onlays, veneers, implants and overdentures.

Alternate Benefit

Alternate benefits applicable to your treatment plan will be determined during predetermination. Should treatment service charges differ from the precertification, the plan reserves the right to determine if alternate benefit is applicable to the actual services rendered.

If the plan pays benefits based on a lower reimbursed service, in accordance with this section, you may be responsible for the excess treatment service charges between what the plan pays and what is billed.

Dental Review

Precertification will be conducted by licensed dentists who review the clinical documentation submitting by your treating dentist. These dentists review this material checking for dental necessity for certain procedures such as crowns, bridges, onlays, implants, periodontal treatments, as well as other services. This dentist may recommend an alternate benefit be applied to a service in accordance with the terms of this plan; therefore, it is important that these dental services are pre-determined so you and your dentist are aware of the coverage terms and benefits before services are performed.

What is Covered

All time limitations for services are based on the last service date. For a detailed list of all services covered, please go to AveraHealthPlans.com or call our Service Center.

Basic Coverage
Member Coinsurance: 0% Services are not subject to your medical deductible.
Diagnostic and Treatment
• Dental examinations, visits and consultation, 1 examination every 6 months
Preventive Services
• Cleanings, 1 cleaning every 6 months
• Fluoride treatment (topical), 2 applications every 12 months
• Bitewing X-rays, 1 set every 6 months
• Sealants – 1 sealant per tooth every 36 months

Intermediate Coverage
Member Coinsurance: 30% Services are not subject to your medical deductible.
Minor Restorative Services
• Resin based anterior composites (alternate benefit of amalgam for molar teeth)
• Prefabricated stainless steel crowns (1 per tooth in 60 months)
Endodontic Services
• Therapeutic pulpotomy (exclusions apply)
Periodontic Services
• Periodontal scaling and root planing – 4 or more teeth, per quadrant, 1 every 24 months
Prosthodontic Services
• Rebase of complete maxillary dentures – 1 in 36 month period; 6 months after initial installation.
Oral Surgery
• Removal of an impacted tooth
• Surgical access of an un-erupted tooth
Major Coverage
Member Coinsurance: 50% Services are not subject to your medical deductible.
Major Restorative Services
• Metallic Onlays – 1 per tooth every 60 months
• Porcelain or ceramic crown substrate – 1 per tooth every 60 months
Endodontic Services
• Anterior, bicuspid and molar root canal (exclusions apply)
• Retreatment of anterior, bicuspid and molar root canal therapy (exclusions apply)
Periodontic Services
• Gingivectomy or Gingivoplasty – 1 to 3 teeth, per quadrant, 1 every 36 months
Prosthodontic Services
• Porcelain, ceramic and cast metal retainers for resin bonded fixed prosthesis – 1 every 60 months
Implant Services
• Services are subject to plan guidelines
Orthodontic Services
Member Coinsurance: 50% Services are not subject to your medical deductible.
• Orthodontia procedures which help restore oral structures to health and function and to treat serious medical conditions such as cleft palate and cleft lip; maxillary/mandibular micrognathia (underdeveloped upper or lower jaw); extreme mandibular prognathism or severe asymmetry (craniofacial anomalies)
Anesthesia Services
Member Coinsurance: 30% Services are not subject to your medical deductible.
• Sedation (not including anesthesia or oral)

What is Not Covered

- Services and treatment not prescribed by or under the direct supervision of a dentist, except in those states where dental hygienists are permitted to practice without supervision by a dentist
- Services and treatment resulting from failure to comply with professionally prescribed treatment
- Services related to the diagnosis and treatment of temporomandibular joint dysfunction
- Duplicate, provisional and temporary devices, appliances and services
- Fabrication of athletic mouth guard
- Oral sedation or anesthesia
- Repair or replacement of damaged, lost, stolen or missing devices or appliances
- Adjustment of a denture or bridgework which is made within 6 months after installation (if completed by the same provider)
- Removal of fixed space maintainer
- Plaque control programs, oral hygiene instruction, tobacco counseling and dietary instruction
- Use of materials or home health aids to prevent decay (such as toothpaste, fluoride gels/rinse and dental floss)
- Services to alter vertical dimension and/or restore or maintain the occlusion. Such procedure include (but are not limited to) equilibration, periodontal splinting, full mouth rehabilitation and restoration of misalignment of teeth
- Hospital costs or additional fees as a result of treatment at the hospital (inpatient or outpatient)
- Gold foil restorations
- Decalcification procedures
- Sealants for teeth other than unrestored permanent molars
- Bone grafts when done in connection with extractions, apicoetomies or non-covered/non-eligible implants
- Select radiographic imaging: TMJ arthrogram, other TMJ imaging and tomographic survey
- Select dental testing: saliva analysis, viral culture, caries testing, adjunctive pre-diagnostic testing, special staining, immunohistochemical stains, tissue in-situ hybridization, direct/in-direct immunofluorescence, electron microscopy and accession transepithelial sampling
- Select orthodontia procedures: rapid palatal expansion, component part placement, interceptive orthodontic treatment, comprehensive orthodontic treatment (during which orthodontic appliances have been placed for active treatment and periodically adjusted), removable appliance therapy and orthodontic retention (removal of appliances, construction and placement of retainers)
- Any services that are considered strictly cosmetic in nature (including teeth whiteners, whitening or bleaching procedures)
- Specialized procedures and techniques (such as precision attachments, personalization or precious metal bases)

- Services and treatment which are for any illness or bodily injury which occurs in the course of employment if a benefit or compensation is available
- Services and treatment for injuries resulting from the maintenance or use of a motor vehicle
- Services and treatment for injuries resulting from war or act of war, self-inflicted injury or illness or committing/attempting to commit a felony and/or engaging in illegal occupation or activities
- Services and treatment which are not dentally necessary or which do not meet generally accepted standards of dental practice
- Services and treatment which are experimental or investigational
- Any charges incurred for failure to keep a schedule appointment
- Any charges incurred for copies and distribution of your records, charts or X-rays
- Any charges for the completion of forms or telephone consultations
- Office infection control charges
- State or territorial taxes on dental services
- Services provided free-of-charge by any governmental entity or provided with no obligation to pay, except where this exclusion is prohibited by law

Pediatric Vision Coverage Addendum

If you are enrolled in this plan, you are entitled to the benefits described below. All benefits are offered through VSP plan. See **vsp.com** or call 1-800-877-7195 for more information concerning the coverage.

Other requirements such as, but not limited to, in-network/out-of-network providers, work-related injury, claim filing, complaint procedures, right of recovery, eligibility and enrollment, coordination of benefits, termination, continuation provisions and other general provisions noted in the Individual Health Insurance Policy are applicable to this addendum unless otherwise noted below.

All benefits are subject to the definitions, limitations and exclusions listed and are payable only when deemed necessary for the prevention, diagnosis, care or treatment of a covered condition and meet generally accepted vision protocols.

Eligibility

Coverage is provided for members up to age 19. If the member turns 19 in the middle of a plan year, coverage is provided until the end of the month of their 19th birthday.

Identification Cards

You can use your member ID card; you do not need a separate card for vision services.

Where Can I Get Covered Care

Select a provider from the VSP network. Visit **vsp.com** to find a doctor in your area.

Do I Need an Authorization?

No prior authorization is needed.

What is Covered

BENEFIT	DESCRIPTION	CO-PAY (Your cost)	FREQUENCY
Your Coverage with a VSP Advantage Doctor			
Exam	• A thorough eye exam that tests for childhood eye health and vision issues, like nearsightedness, amblyopia (lazy eye), and strabismus.	$0	Every 12 months
Prescription Glasses			
Frames	• Frames covered in full from our designated frame collection	$0	Every 12 months

Lenses	• Single vision, lined bifocal, lined trifocal, or lenticular lenses • Polycarbonate, scratch-resistant coating, and UV protection	$0 Included in Prescription Glasses	Every 12 months
Lens Options	• 20% - 25% off other lens options	N/A	Every 12 months
Contacts (Instead of glasses)	Elective Contact lenses A Standard or Premium fit contact lens exam (fitting and evaluation) is covered in full. Contact lenses are in lieu of frame and lenses. Members can choose from any available prescription contact lenses. Prescription contact lenses are covered with a minimum three-month supply for any of the following modalities: • Standard (one pair annually) = 1 contact lens per eye (total 2 lenses) • Monthly (six-month supply) = 6 lenses per eye (total 12 lenses) • Bi-weekly (three-month supply) = 6 lenses per eye (total 12 lenses) • Dailies (three-month supply) = 90 lenses per eye (total 180 lenses) .	$0	Every 12 months
Extra Savings and Discounts	**Glasses and Sunglasses** • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor within 12 months of your last exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

What is Not Covered

Not Covered: Items such as:

- Insurance policies or service agreements
- Artistically painted or non-prescription lenses
- Additional office visits for contact lens pathology
- Contact lens modification, polishing or cleaning

The following items are excluded under this plan:

- Two pairs of glasses instead of bifocals
- Replacement of lenses, frames or contacts

- Medical or surgical treatment
- Orthoptics, vision training, supplemental testing