# MAJOR MEDICAL BENEFITS

The following provisions apply to the $750 Deductible Plan, the $1,250 Deductible Plan, and the $1,800 Deductible Plan. Reference the Master Schedule of each plan for more information.

Within the provisions of Plan coverage, the Plan Administrator will pay the benefit, if any, for covered charges Incurred:

(a) As result of Injury, disease, or Pregnancy; and

(b) While the Employee is covered on the South Dakota State Employee Health Plan.

In any one Plan Year, the benefit will be equal to an amount determined by removing any applicable Deductible and Copayments (member responsibility), and then multiplying the remainder by the applicable Coinsurance amounts that apply:

(a) Covered Hospital charges Incurred by the Member;

(b) Covered surgical charges Incurred by the Member; and

(c) Covered medical charges Incurred by the Member.

The Plan Administrator will not pay more than the Benefit Maximum for all covered charges Incurred by the Member in his or her lifetime. (See “Master Schedule.”)

Benefit Percentages, applicable Deductible and Copayments, Benefit Maximums, and Plan Year Maximums are shown in the Master Schedule.

### *MEDICAL OUT-OF-POCKET MAXIMUM*

A medical Out-of-Pocket Maximum will apply in each Plan Year to any Member of the State Plan. The limit equals the maximum amount of covered charges that a Member is responsible for.

Amounts that apply to the medical Out-of-Pocket Maximum include:

(a) The Deductible;

(b) Benefit percentages (Coinsurance); and

(c) Copayments.

When the Out-of-Pocket Maximum is reached during a Plan Year, the Plan will pay 100% for most covered charges thereafter Incurred in that Plan Year. Out-of-Pocket Maximums are shown in the Master Schedule.

The following do not apply to the medical Out-of-Pocket Maximums:

(a) Charges above the contracted rate for DAKOTACARE or other participating providers if the covered Member does not use approved facilities. Member is responsible for paying the charges above the contracted rate;

(b) Charges above the Plan Maximum Allowable Charges (MAC) or Usual, Customary, and Reasonable (UCR) charges. Member is responsible for paying the charges above the MAC or UCR;

(c) Charges for services not covered by the Plan;

(d) Penalties for not obtaining a second opinion when required;

(e) Penalties Incurred when Pre-authorization is not arranged when required; and

(f) Prescription drug Copayments. Prescription drug Copayments for the $750 Deductible Plan and $1,250 Deductible Plan apply to separate $1,000 per person or $2,500 for family of three or more per Plan Year drug Out-of-Pocket maximum.

NOTE: The State reserves the right to regulate the choice of provider, services, or supplies based on variable criteria that can include cost savings or service excellence. The member may choose a provider, service, or supply other than one approved by the State, but the member will be responsible for any cost differences. The Plan will only pay the amount they would have paid for the approved provider, service, or supply. The member is responsible for all remaining charges. These additional amounts will not apply to the annual medical Out-of-Pocket Maximum.

## *OBTAINING HEALTH SERVICES*

DAKOTACARE providers will be the primary source of medical care for Members. If health services are received from non-DAKOTACARE providers, benefits may be limited.

DAKOTACARE providers may prescribe, order, or recommend the services of, or refer a Member to a non-DAKOTACARE provider; however, this does not make such services eligible for reimbursement under the terms of this Plan. To be reimbursed, services must be covered by this Plan, must be provided while the Member is enrolled in the Plan, and must be Medically Necessary.

## *MEDICALLY NECESSARY TREATMENT*

The State reserves the right to determine if a service or supply is Medically Necessary. Many services will be reviewed for appropriateness and medical necessity before the services are rendered, through the Pre-authorization process. Other services, such as emergency care, emergency transportations, and private duty nursing, may be reviewed for appropriateness and medical necessity after treatment is provided.

Services that are not Medically Necessary will not be covered by the Plan.

Pre-authorization by HMP or DAKOTACARE does not guarantee coverage under the Plan. The services must still fall within Plan provisions and the definition of covered services, and must not exceed Plan maximums. The Member receiving the service must also be eligible for coverage at the time the service is provided.

## *USUAL, CUSTOMARY, AND REASONABLE CHARGES (UCR) AND/OR MAXIMUM ALLOWABLE CHARGES (MAC)*

Usual, Customary, and Reasonable charges (UCR) or Maximum Allowable Charges (MAC) are the maximum amount that will be covered by the Plan for eligible charges. DAKOTACARE providers agree to accept these maximums as payment in full for those services. Generally, when a DAKOTACARE provider is used, the Member is not responsible for paying charges in excess of UCR or MAC.

NOTE: The State reserves the right to regulate the choice of provider, services, or supplies based on variable criteria that can include cost savings or service excellence. The member may choose a provider, service, or supply other than one approved by the State, but the member will be responsible for any cost differences. The Plan will only pay the amount they would have paid for the approved provider, service, or supply. The member is responsible for all remaining charges. These additional amounts will not apply to the annual medical Out-of-Pocket Maximum.

## *COVERED CHARGES*

Members shall be entitled to Medically Necessary services and supplies, if provided by or under the direction of a Physician. These services are subject to:

1) The limitations, exclusions, and other provisions of the Plan;
2) Payment by the Member of any applicable Deductible, Copayment, and Coinsurance specified for any service; and
3) Pre-authorization by Health Management Partners (HMP) or DAKOTACARE, in certain instances.

(a) Charges for the following services qualify as covered Hospital charges if the services are for a Hospital stay; days of inpatient care at an Extended Care Facility (ECF); or Acute Rehabilitation Facility. These services include:

1) Semiprivate room and board provided the daily charge is Medically Necessary; pre-authorized by HMP; and does not exceed the maximum covered room and board charge shown in the Master Schedule.

2) Other Medically Necessary services and supplies for the Member during the stay such as:
   - Durable medical equipment;
   - Diagnostic and therapeutic services;
   - Lab and x-rays;
   - Speech, occupational, or physical therapy; or
   - Blood and blood plasma (administration of services and supplies covered when charged by the Hospital, ECF, or Acute Rehabilitation Facility-special nursing and Physician services not included).

NOTE: Medically Necessary covered medications prescribed and administered during an approved confinement. Care provided in an ECF or Acute Rehabilitation Facility must be ordered by a Physician and in place of a Hospital stay.

(b) Covered surgical charges for surgery performed in a Hospital, physician office, clinic, or ambulatory surgical facility include:

1) Fees for a Surgical Procedure performed by a Physician, limited to Usual, Customary, and Reasonable (UCR) or the Maximum Allowable Charge (MAC) for the service;

2) Fees for an assistant surgeon (M.D., Physician Assistant, or the equivalent), if Medically Necessary. Such fees will be reimbursed per DAKOTACARE fee schedule;

3) Fees for anesthesia; and

4) One Bariatric Surgery per person per lifetime. The Member must meet certain criteria and be pre-authorized. See "Bariatric Surgery."

(c) Charges for the following services qualify as covered medical charges, but only if not already covered as Hospital or surgical charges:

1) Medical treatment by a Physician;

2) Physician consultation services when Incurred as a result of second surgical opinions or other requirements of the Plan Managed Care Program;

3) Necessary ground or air ambulance service to the nearest facility equipped to treat the illness or Injury. Emergency ground and air ambulance services will be reviewed after treatment to determine appropriateness and medical necessity;

4) Lab tests, x-rays, and other radiology exams;

5) Anesthetics, oxygen, and the administration;

6) Blood, blood plasma, and the administration of blood and blood plasma;

7) Chemotherapy;

8) Optometric services for the diagnosis or treatment of a medical condition or disease (e.g., glaucoma) or for an Injury to the eye. Immediately following surgery, coverage also includes eyeglasses or contact lenses required because of an eye Injury or cataract surgery;

9) Hearing tests when prescribed by a Physician and Medically Necessary or for children up to one year old. Hearing aids of medical necessity and fitting up to age eight. Cochlear implants are covered when Medically Necessary and approved by HMP;

10) Dental services:

i) As needed due to an Injury to sound natural teeth unless, Injury to the teeth or their surrounding tissue or structure is caused by chewing. Services must begin within 12 months of the Injury;

ii) For surgical removal of impacted or partially impacted teeth;

iii) For removal of tumors or cysts;

iv) For drainage of an abscess or cyst; or

v) Covered under this health plan are considered primary to any other dental policy.

11) Services and supplies provided for a jaw condition if needed due to an Injury, Medically Necessary surgery, or treatment of TMJ (temporomandibular joint syndrome);

Medically Necessary treatment of TMJ is limited to a $5,000 Benefit Maximum per person. The TMJ maximum includes diagnosis, treatment, appliances, and surgery needed to correct this condition of the jaw;

12) Medically Necessary speech, occupational, or physical therapy is eligible with prior authorization, regardless of diagnosis. Therapy must be prescribed by a Physician, with treatment beginning within 30 days from the date of the Physician's prescription.

Therapy ordered by a physician that is received in addition to or above the *Birth to Three Program* or received in addition to or above therapy in the school systems is a covered benefit when it meets medical necessity. Speech therapy services meet the definition of medical necessity when performed to restore or improve speech in members who have a swallowing or speech-language disorder that is associated with:

- An acute illness or condition (e.g., dysphagia, GERD);
- An acute exacerbation of chronic illness or condition;
- An acute injury or trauma;
- A surgical procedure;
- A congenital defect (e.g., cleft palate, cleft lip, etc.); or
- Cerebrovascular accident (stroke).

Speech therapy is typically offered in school settings and in developmental learning centers. Speech therapy services do not meet the definition of medical necessity for conditions such as, but not limited to, the following:

- Psychosocial speech delay;
- Behavioral problems;
- Attention disorders;
- Learning disabilities;
- Developmental delay that is not the result of a specific genetic disorder; or
- Stammering, stuttering.

13) Infertility diagnosis and Medically Necessary treatment up to a $3,000 Benefit Maximum for all services (excluding infertility drugs). The Health Plan does not cover charges for artificial insemination or in vitro fertilization;

14) Initial rental or purchase, at the Plan option, of Medically Necessary Durable Medical Equipment, such as but not limited to crutches, braces, wheelchairs, and other prostheses needed for the treatment of a disease, illness, or Injury.

Repairs or replacements of prostheses and other equipment must also be considered Medically Necessary for the condition, and be consistent with current equipment. See "Benefit Exclusions" for exceptions;

15) Charges for covered services provided at the South Dakota Human Services Center or performed by nurses of the South Dakota Department of Health acting within the scope of their license;

16) Services provided by the South Dakota Department of Health Family Planning Clinics including contraceptive implants and removal, and Depo-Provera injections;

17) Acupuncture performed by a qualified provider, such as a Physician or Chiropractor. The Plan does not cover services provided by an acupuncturist;

18) Chelation therapy that is Medically Necessary and pre-authorized;

19) Radioactive isotope therapy; and

20) Radiotherapy.

(d) Charges for the following qualify as covered home healthcare charges but only to the extent that the charges are pre-authorized as Medically Necessary and received during convalescence in the Member's home:

1) Skilled nursing care provided or supervised by a registered nurse, affiliated with a licensed home healthcare agency;

2) Home health aide services (mainly Patient care);

3) Physician ordered physical, occupational, speech, and respiratory therapy;

4) Medical social services by a licensed medical or psychiatric social worker who is supervised by a Physician;

5) Medical supplies and equipment; and

6) Medically Necessary private-duty skilled nursing when part of a written home healthcare treatment plan and provided by a nurse affiliated with a licensed home healthcare agency.

NOTE: See "Benefit Exclusions" for exceptions.

(e) Hospice care provided in the home, or an approved facility that is pre-authorized. See "Benefit Exclusions" for exceptions.

(f) The Plan covers charges for non-experimental transplant services approved by the Food and Drug Administration such as:

1) Bone marrow and stem cell transplants for certain conditions;

2) Cornea;

3) Heart;

4) Heart/lung;

5) Kidney;

6) Kidney/pancreas;

7) Liver; or

8) Lung.

Benefits are payable for both recipients and donors covered by the Plan. Covered charges Incurred during the transplant period include, but are not limited to:

1) Pre-transplant evaluation;

2) Organ procurement/listing fees, surgical, storage and transportation costs by the donor or Incurred and directly related to the donation of the organ used in an organ transplant procedure. Reasonable transportation costs to and from the site of transplant procedure are covered for the donor and a companion for the evaluation and procedure only. The Benefit Maximum for eligible donor services will not exceed $50,000 per person;

3) Inpatient expenses and medication;

4) Professional fees;

5) Reasonable transportation costs (mileage reimbursement based on the IRS medical mileage) to and from the site of the transplant procedure are covered for the transplant recipient and a companion for the initial evaluation and procedure only;

6) Necessary and reasonable lodging for the transplant recipient and a companion Incurred during the transplant procedure based on U.S. General Services Administration allowables; and

7) Medically Necessary follow-up care.

NOTE**:** The transplant benefit period is defined as the period of time from the date the Member receives Pre-authorization and has an initial evaluation for the transplant procedure until one year after the date the procedure was performed. For maximum benefits, services must be pre-approved and provided by an approved facility as determined by the Plan. If a member chooses a facility other than one approved by the State, the member will be subject to Out-of-Network benefits, including deductible, coinsurance and out of pocket maximum.

(g) Preventive Cancer Screening procedures.

(h) Reconstructive Services.

1) In compliance with the Women's Health and Cancer Rights Act, if a covered individual receives benefits in connection with a mastectomy, the South Dakota State Employee Health Plan covers reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas;

2) Needed due to an accident; or

3) Needed due to a birth defect when Medically Necessary.

(i) Charges for chiropractic treatments, chiropractic massages via electronic modality, and chiropractic services.

(j) The South Dakota State Employee Health Plan provides the following maternity health benefits for covered members:

1) Charges for prenatal care, delivery, and postpartum examinations. Blood tests and pap smears performed during the prenatal exam or postpartum checkup;

2) Charges for services and Medically Necessary supplies associated with midwife deliveries, birthing centers, and home delivery, as long as a licensed medical professional or midwife is present;

3) In compliance with the Newborns' and Mothers' Health Protection Act of 1996, the Plan provides a minimum of 48 hours of inpatient care for a mother and her newborn following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by 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 if applicable). 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); and

4) One follow up home visit will be covered even if the mother and/or child are hospitalized for the entire 48 or 96 hours.

NOTE: Newborns of dependents are not covered. See Benefit Exclusions.

(k) Benefits are payable for diagnosis and inpatient and outpatient treatment for mental and nervous conditions by a DAKOTACARE provider or Qualified Mental Health Professional (QMHP). Physicians licensed pursuant to SDCL 36-4 are considered Qualified Mental Health Professionals and are not required to receive the endorsement by the South Dakota Department of Human Services.

NOTE**:** The Health Plan will cover Biologically-Based Mental Illnesses in the same way as other covered illnesses. Biologically-Based Mental Illness means any mental illness which current medical research affirms is caused by a neurobiological disorder of the brain; which substantially impairs perception, cognitive function, judgment, and emotional stability; and which limits the life activities of the person with the illness. The term includes schizophrenia, schizoaffective disorder, bipolar affective disorder, major depression, obsessive-compulsive disorder, and other anxiety disorders, which cause Significant Impairment of Function, and other disorders proven Biologically-Based Mental Illnesses. See "Words and Phrases."

The Plan covers mental health treatment as follows:

1) Inpatient treatment for mental and nervous conditions requires Pre-authorization and are covered the same as any other Hospital stay;

2) Outpatient treatment of mental and nervous conditions are covered the same as any other covered illness; and

3) Residential Day treatments for mental and nervous conditions requires Pre-authorization and are covered the same as any other covered illness.

Covered services may include:

1) Evaluations and individual and group therapy (for the Member); or

2) When Patient is present, family counseling in cases of depression and attention deficit disorder.

(l) Benefits are payable for inpatient and outpatient treatment for alcohol and substance abuse by a DAKOTACARE provider, Certified Chemical Dependency Counselor (CCDC), or Qualified Mental Health Professional (QMHP). Physicians licensed pursuant to SDCL 36-4 are considered Qualified Mental Health Professionals and are not required to receive the endorsement by the South Dakota Department of Human Services.

Pre-authorization is required for inpatient and residential day treatment of alcohol and substance abuse.

(m) Cardiac self-management training and education. Pre-authorization is required.

(n) Ossatron lithotripsy procedures (extracorporeal shock wave treatment for chronic Proximal Plantar Fasciitis). The Plan covers facility and Physician charges associated with this procedure. Benefits are limited to a $5,000 Benefit Maximum per person.

(o) HIV tests.

(p) End Stage Renal Disease pharmaceuticals prescribed for Medicare recipients (not including age 65 and Retirees).

(q) Screening for Sickle Cell disease in newborns.

(r) Physician prescribed intravenous feeding following the diagnosis of Mucopolysaccharidosis type IVA.

(s) Physician prescribed dietary management and formula for the treatment of phenylketonuria (PKU).

(t) Amino Acid-Based Elemental Formulas for children age five and under for treatment of maldigestion or malabsorotion associated with the following conditions:

(1) Immunoglobulin E and non-immunoglobulin E medicated allergies to multiple food proteins;
(2) Severe food protein induced enterocolitis syndrome;
(3) Eosinophilic esophagitis;
(4) Eosinophilic gastroenteritis;
(5) Eosinophilic colitis;
(6) Amino acid, organic acid or fatty acid metabolic malabsorption disorders; and

(7) Impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length, and motility of the gastrointestinal tract.

Amino Acid-Based Elemental Formulas are not covered for all other conditions including milk allergy and the treatment of simple caloric deficits in Members with normally functioning gastrointestinal tracts.

The Amino Acid-Based Element Formulas must be prescribed in writing by a pediatrician, allergist, or gastroenterologist.

(u) Diabetic supplies for insulin infusion pumps, diabetic monitors, and ostomy supplies.

(v) Maternity services include obstetrical care for a Pregnancy (e.g. including one Physician visit per month for weeks 0-28, two visits per month for weeks 29-36, and one visit per week for weeks 37 to delivery), delivery and postpartum care, lab charges and other ancillary services associated with Office Visits. Additional covered benefits for expectant mothers who enroll in Our Healthy Baby program.

(w) Genetic testing will be covered when all of the following criteria have been met:

1) The targeted treatment is a covered benefit of the healthcare plan;
2) The individual is a candidate for the targeted treatment;
3) The genetic testing results will directly impact the treatment plan and medical outcomes;
4) The testing method is scientifically proven to be valid in detecting the specified gene and the relationship between the gene and treatment have been validated through randomized control trials; and
5) Genetic testing resulting in a negative correlation with the targeted treatment may result in a denial of the targeted treatment.

NOTE: The State reserves the right to regulate the choice of provider, services, or supplies based on variable criteria that can include cost savings or service excellence. The member may choose a provider, service, or supply other than one approved by the State, but the member will be responsible for any cost differences. The Plan will only pay the amount they would have paid for the approved provider, service, or supply. The member is responsible for all remaining charges. These additional amounts will not apply to the annual medical Out-of-Pocket Maximum.

## *BENEFIT EXCLUSIONS*

The Plan does not pay any benefits for the following services or supplies. Refer to “Covered Charges” for exceptions.

(a) Incurred in connection with any services provided before the Member was covered by the Plan or after coverage ends.

(b) Not Medically Necessary, except for routine care of a newborn received during the Hospital stay which begins at birth.

(c) Provided without a Physician prescription, recommendation, or approval.

(d) Services, supplies, medications, or devices which are determined to be Experimental or Investigational in nature, in research development, or are used in a manner not approved by the

United States Food and Drug Administration, except for off-label drug use recognized for treatment of certain indicators by standard reference compendia.

(e) Excess costs above the Plan accepted maximums – Usual, Customary, and Reasonable (UCR) charges or Maximum Allowable Charges (MAC) - when the Member receives services from a non-DAKOTACARE provider.

(f) The cost difference when a member chooses a provider, service or supply that is not an approved provider, service or supply by the plan.

(g) Provided in connection with Custodial Care.

(h) Provided by or as a benefit under Medicare or any other Healthcare Plan.

(i) Which would not have been billed if benefits were not available.

(j) For which no one is legally required to pay.

(k) For which the State of South Dakota cannot legally provide benefits.

(l) An Injury or sickness, which arises out of or in the course of any employment for wage or profit and is paid by workers' compensation.

(m) For any Injury, illness, or disability sustained while serving on full-time active duty in the armed forces of declared war or undeclared war, including resistance to armed aggression.

(n) Injuries sustained while participating in a felony or a riot or while incarcerated because of a felony or riot.

(o) Any attempt to defraud this Plan.

(p) Any Injury sustained while the covered individual is under the influence of alcohol or any narcotic, unless the narcotic is prescribed by a licensed Physician.

(q) Services rendered by the Employee, a member of the Employee's family, or by any person who resides in the Employee's home. The Employee's family consists of the Employee, the Employee's spouse, and children, brothers, sisters, and parents of either the Employee or the Employee's spouse.

(r) School physicals, sports or employment-related physicals.

(s) Routine screenings for hepatitis except in the event of maternity.

(t) Charges for food, food substitutes, food supplements including infant formulas, and vitamins that are purchased for consumption on an outpatient basis, whether prescribed or not except as indicated under "Covered Charges." Charges are allowed in the event of outpatient Hospice care when a feeding tube is required.

(u) Drugs or supplies, or prescribed drugs/supplies, which are available over the counter except as, indicated under "Covered Charges or Preventive Medications."

(v) Personal comfort or convenience items while Hospitalized including but not limited to TV usage and telephone usage.

(w) Durable medical equipment prescribed solely for convenience or because it is the most recent model including but not limited to:

- Sauna and whirlpool devices;
- Items and supplies related to the use of Durable Medical Equipment (e.g., batteries, battery chargers, AC/DC adapter plugs, blood pressure cuffs, etc.);
- Wheelchair; and
- Cochlear implant batteries.

(x) Exercise equipment and club membership even when prescribed or recommended by a Physician.

(y) Whirlpool or aqua-massage therapy.

(z) Any treatments or services that have no ability to cure medical conditions, but are used only to alleviate symptoms or behaviors (e.g., massage therapies) except as indicated under "Covered Charges."

(aa) To reconstruct an external part of the body for cosmetic reasons or to correct a developmental defect except as indicated under "Covered Charges."

(bb) Enhancements designed to facilitate personal lifestyle choices (whether Medically Necessary or not), including services and supplies intended mainly to improve personal performance or appearance, provided primarily to beautify, or minoxidil in any of its forms.

(cc) Weight control treatments, whether inpatient or outpatient, unless approved by Health Management Partners (HMP).

(dd) Any eye care service or supply provided for diagnosis or treatment of astigmatism, myopia, hyperopia, or presbyopia, including eye examinations and surgery.

(ee) Eyeglasses, contact lenses, and their fitting, except when needed immediately following surgery for an Injury to the eye or following cataract surgery.

(ff) Audiology (hearing) tests except as indicated under "Covered Charges."

(gg) The fitting or cost of a hearing aid or earplugs except as indicated under "Covered Charges."

(hh) Dental treatment except as indicated under "Covered Charges."

This exclusion includes implants, gingivitis, orthodontic services, veneers, periodontal treatments and surgery, caps/crowns, prosthesis and removal, care or alignment of the teeth because of an Injury to the teeth (or their surrounding tissue or structure) caused by chewing.

(ii) Charges in connection with a dependent's newborn.

(jj) Routine foot care, except Medically Necessary custom fit orthotic devices.

(kk) Transportation or lodging, except as provided under ambulance, required second surgical opinion or organ transplant benefits.

(ll) Religious counseling and marital counseling.

(mm) Treatment for compulsive gambling.

(nn) Family group therapy (e.g., parent/child relationships) when the Patient is not present.

(oo) The use of CPAP's (Continuous Positive Airway Pressure) when used solely to control behavior problems or to resolve behavioral issues.

(pp) Recreational or educational therapy and other forms of non-medical self-care, unless provided as part of Plan-approved Diabetic or Cardiac Education or rehabilitative care. This includes learning disability therapy and treatment normally provided through other mandated programs.

(qq) Wigs needed for hair loss resulting from any medical condition.

(rr) Artificial insemination, invitro fertilization, or treatment or drugs to reverse a sterilization procedure.

(ss) Treatment or drugs to terminate a Pregnancy unless the mother's health is in danger or the Pregnancy is due to rape.

(tt) Laetrile use in any form.

(uu) Biofeedback. massage therapy, and pain management therapy/treatment.

(vv) Treatment or drugs prescribed in connection with milieu or milieu therapy.

(ww) Services or drugs related to gender transformations.

(xx) Charges covered by automobile or homeowners insurance that provides medical coverage while the policy is in effect.

(yy) Ergonomic or other home or worksite evaluations.

(zz) Construction, remodeling, or the structural alteration of a residence, vehicle, or workplace to accommodate the access to, mobility in, or use of the residence.

(aaa) Charges for smoking cessation classes, unless offered or sponsored by the South Dakota State Employee Health Plan.

(bbb) Charges for missed medical appointments.

(ccc) The cost of a second procedure/surgery if it can be determined that the procedure must be redone and is necessary because Physician instructions were not followed. The Member is responsible for 100% of the cost of the second procedure, and the cost of the second procedure/surgery does not apply to the annual medical Out-of-Pocket Maximum.

(ddd) The following charges do not qualify as covered home healthcare charges:

1) Charges for services rendered by the Employee, a member of the Employee's family, or by any person who resides in the Employee's home. The Employee's family consists of the Employee, the Employee's spouse, and children, brothers, sisters, and parents of either the Employee or the Employee's spouse; or

2) Charges for Custodial Care.

(eee) Outpatient prescription drugs except as covered by CVS Caremark under the pharmacy component of the Health Plan.

(fff) Applied Behavior Analysis (ABA) therapy or related socialization or behavior modification therapies.

(ggg) Services, supplies, or medications related to or treatment in connection with sexual dysfunction or sexual inadequacy, whether organic or psychological in nature.

(hhh) Costs incurred for additional treatment when member self discharges or discontinues medical treatment against medical advice.

(iii) Services related to and required as a result of services that are not covered. Medical and hospital services that are related to and required that arose solely as a result of services that are not covered by the plan will not be paid. Some examples of these services are:

- Cosmetic surgery;
- Non-covered organ transplants; and
- Services related to follow-up care or complications that arose solely as a result of the treatment during a hospital stay in which a non-covered service is performed.

Exceptions:

When a beneficiary is hospitalized for a non-covered service and requires services that are not related to the non-covered service, the unrelated services are covered. For example, if a beneficiary breaks a leg while he or she is in the hospital for a non- covered service, the services to treat the broken leg are covered since they are not related to the non- covered service.

When a beneficiary is discharged from a hospital stay in which he or she receives non-covered services and subsequently requires services to treat a condition or complications that arose and are not related to the non-covered services, reasonable and necessary medical or hospital services may be covered.

## *TIER 1 SERVICES, FACILITIES, AND PROVIDERS*

The State reserves the right to regulate the choice of contracted provider, services, or supplies based on variable criteria that can include cost savings or service excellence. The member may choose a provider, service, or supply other than one approved by the State, but the member may be subject to additional cost. The Plan will only pay the amount they would have paid for the approved provider, service, or supply. The member is responsible for all remaining charges. These additional amounts will not apply to the annual medical Out-of-Pocket Maximum.

### *TIER 1*

Tier 1 is based on the service, facility and provider. ***To receive the highest level of benefit, you must have a Tier 1 service performed at an approved Tier 1 facility by an approved Tier 1 provider.***

Tier 1 facilities have a preferred relationship with State of South Dakota to provide high quality medical and surgical services at reduced costs in a contracted rate that includes fees for: provider, anesthesia, lab work, pathology, and x-ray services for Tier 1 services. The services a member receives at the Tier 1 facility three days prior to a procedure and 30 days after the procedure are covered at a contracted rate. Tier 1 Bariatric services are covered at a contracted rate for a 365 day period.

All Tier 1 services must be pre-authorized by Health Management Partners (HMP). HMP will advise members where Tier 1 services are available if a member is scheduled to have a Tier 1 service. All pre-authorization requirements must be satisfied, and the member must receive confirmation of pre-authorization before having services performed in order to receive the Tier 1 contracted rate.

Only the specific services listed on the Tier 1 Coverage Chart are subject to Tier 1. The Tier 1 Coverage Chart is available at http://benefits.sd.gov/tier1.aspx.

### *NON-TIER 1*

If you have a Tier 1 service at a Non-Tier 1 facility or by a Non-Tier 1 provider, you will have a higher Out-of-Pocket Maximum. The Out-of-Pocket Maximum is determined by which health plan you are currently enrolled in. These amounts are referenced in the Master Schedule for each page.

The In-Network deductible and 75% coinsurance will apply to Non-Tier 1 facilities and providers if services are received in the DAKOTACARE Network.

Non-Tier 1 facilities do not accept the contracted rate that includes fees for the provider, anesthesia, lab work, pathology, and x-ray services. Services three days prior and 30 days after are not included in the rate (365 days for bariatric services) for Non-Tier 1. If a member utilizes a Non Tier 1 facility or provider for a Tier 1 service the member will be billed separately for these services, increasing the cost to the member and the plan.

## *COVERAGE FOR TIER 1*

| **FY15 Coverage for Tier 1** | | | | | |
|---|---|---|---|---|---|
| $750 Deductible Plan | | $1,250 Deductible Plan | | $1,800 Deductible Plan with HSA | |
| Tier 1* | Non-Tier 1 | Tier 1* | Non-Tier 1 | Tier 1* | Non-Tier 1 |
| $750 per person Deductible | $750 per person Deductible | $1,250 per person Deductible | $1,250 per person Deductible | $1,800 per person Deductible<br><br>$3,600 family of three or more deductible | $1,800 per person Deductible<br><br>$3,600 family of three or more deductible |
| 25% Coinsurance | 25% Coinsurance Network Provider | 25% Coinsurance | 25% Coinsurance Network Provider | 25% Coinsurance | 25% Coinsurance Network Provider |
| $3,250 Out-of-pocket maximum | $5,350 Out-of-pocket maximum | $4,250 Out-of-pocket maximum | $5,350 Out-of-pocket maximum | $4,350 Out-of-pocket maximum single | $5,350 Out-of-pocket maximum single |
| $8,125 Out-of-pocket maximum per family of three or more | $10,200 Out-of-pocket maximum per family of three or more | $10,200 Out-of-pocket maximum per family of three or more | $10,200 Out-of-pocket per family of three or more | $10,200 Out-of-pocket maximum family of three or more | $10,200 Out-of-pocket maximum family of three or more |

**** To receive the highest level of benefit, you must have a Tier 1 service performed at an approved Tier 1 facility by an approved tier 1 provider.***

***Note: Non-Tier 1 facilities must be a DAKOTACARE Network Provider otherwise, Out-of-network charges apply.***

## *TIER 1 FACILITIES, SERVICES, AND PROVIDERS*

| **FY15 Tier 1 Facilities, Services and Providers** | | |
|---|---|---|
| Sanford | Avera | Sioux Falls Specialty Hospital |
| <u>Cardiac</u><br>Heart Bypass Surgery<br>Cardiac Catheterization<br>Balloon Angioplasty<br>Pacemakers<br><br><u>Orthopedic</u><br>Back & Neck Surgery (including spinal fusion)<br>Total Knee Replacement<br>Total Hip Replacement<br><br><u>Bariatric</u><br>Weight Reduction Surgery Lap-band, Gastric Sleeve, and Roux-en-Y<br>Must be enrolled and approved through the Bariatric Management program with Health Management Partners | <u>Renal Care</u><br>Kidney Transplants<br>Dialysis | <u>Gastroenterology</u><br>Colonoscopies<br>(does not apply to preventive colonoscopies)<br>Upper GI and/or Endoscopies<br>Hernia Repair<br>Gallbladder |
| Must be a Sanford provider | Must be an Avera provider | SFSH Tier 1 Providers include: Mark Milone, Chandar Singaram, Don Wingert, Dave Strand, Bradley Thaemert, Scott Baker, Mike Person, Michael Bauer |

**** To receive the highest level of benefit, you must have a Tier 1 service performed at an approved Tier 1 facility by an approved tier 1 provider.***

## *OUT OF COUNTRY COVERAGE*

Members traveling or residing out of the country receive the same level of benefits for eligible charges as Plan members residing within the country. Usual, Customary, and Reasonable (UCR) limits apply to these charges. To ensure prompt payment of claims, provider bills and other documentation must be translated into readable English and converted into American dollar amounts. Conversion to American dollars is calculated using exchange values from date the services were Incurred prior to submission.

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