CLAIMS ACTION

To receive benefits, the Member or the provider must file a claim for services. Participating DAKOTACARE providers will file claims on behalf of the Patient.

Benefits will not be paid until the Member has sufficient medical expenses to satisfy the Plan Year Deductible. Claims must be filed within one year after the end of the Plan Year in which expenses are Incurred. If the Member's claim is late, it will not be denied or reduced if the Member can show that the claim was submitted within a reasonable time.

The Member may request benefits be paid directly to him or her. However, the State, as the Employer, reserves the right to assign benefit payments to a healthcare provider or to the Member or a covered Spouse or Dependent. Formal cost containment agreements with providers may preclude sending benefit payments directly to Members or covered Spouse or Dependent.

After filing a claim, the Member will receive an Explanation of Benefits (EOB) statement from the Claims Administrator processing the claim. The EOB will explain in detail the amount of benefit received for each item in the claim.

APPEALING A DENIED CLAIM

The Member will be notified in writing if a claim for benefits is denied. The EOB will include the specific reason(s) the claim was denied.

If a claim is denied, the Member may appeal to the Director of Employee Benefits, c/o the Bureau of Human Resources, within 30 days of receiving notification of the denial. The Member will receive a decision within 30 days from the date the complaint is received. If the Member's claim is still denied, the Member may appeal in writing to the Commissioner of the Bureau of Human Resources, who may hold a hearing by the Office of Hearing Examiners.

If the claim is again denied, the Member may appeal the decision to the circuit court in accordance with SDCL 1-26.

LEGAL ACTION

No legal action or suit to recover on the Plan may be started before 60 days after written proof of loss has been furnished. Further, no legal action or suit may be brought more than 3 years after the time proof of loss must be furnished. But, if either time limit is less than permitted by state law where the Member resides when the loss occurs, that limit is extended to agree with the shortest limit the law of that state allows.

SUBROGATION

When a Member is injured or becomes ill because of the actions or inactions of a third party, the Plan may cover eligible health care (medical, dental, and vision) expenses. However, to receive coverage, the Member must notify the Plan that your illness or Injury was caused by a third party, and you must follow special Plan rules. This section describes the procedures with respect to subrogation and right of recovery.

Subrogation means that if an Injury or illness is the fault of someone else, the Plan has the right to seek expenses it pays for that illness or Injury directly from the at-fault party or any of the sources of payment listed later in this section. A right of recovery means the Plan has the right to recover such expenses indirectly out of any payment made to the Member by the at-fault party or any other party related to the illness or Injury.

By accepting Plan benefits to pay for treatments, devices, or other products or services related to such illness or Injury, you agree that the Plan:

- Has an equitable lien on any and all monies paid (or payable) to you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or Injury;

- May appoint you as constructive trustee for any and all monies paid (or payable to) you or for your benefit by any responsible party or other recovery to the extent the Plan paid benefits for such sickness or Injury; and

- May bring an action on its own behalf or on the covered person's behalf against any responsible party or third party involved in the sickness or Injury.

If you (or your attorney or other representative) receive any payment, however characterized, from the sources listed later in this section – through a judgment, settlement or otherwise – when an illness or Injury is a result of a third party, you agree to place the funds (without reduction for attorney's fees or otherwise) in a separate, identifiable account and that the plan has an equitable lien on the funds, and you agree to serve as a constructive trustee over the funds to the extent that the Plan has paid expenses related to that illness or Injury. This means that you will be deemed to be in control of the funds.

You must pay the Plan back first, in full, out of such funds for any health care expenses the Plan has paid related to such illness or Injury. You must pay the Plan back up to the full amount of the compensation you receive from the responsible party, regardless of whether your settlement or judgment says that the money you receive (all or part of it) is for health care expenses. Furthermore, you must pay the Plan back regardless of whether the third party admits liability and regardless of whether you have been made whole or fully compensated for your Injury. If any money is left over, you may keep it.

Additionally, the Plan is not required to participate in or contribute to any expenses or fees (including attorney's fees and costs) you incur in obtaining the funds. The Plan's sources of payment through subrogation or recovery include, but are not limited to the following:

- Money from a third party that you, your guardian or other representatives receive or are entitled to receive;

- Any constructive or other trust that is imposed on the proceeds of any settlement, verdict or other amount that you, your guardian or other representatives receive;

- Any equitable lien on the portion of the total recovery which is due the Plan for benefits it paid; and

- Any liability or other insurance (for example, uninsured motorist, underinsured motorist, medical payments, workers' compensation, no-fault, school, homeowners, or excess or umbrella coverage) that is paid or payable to you, your guardian, or other representatives.

As a Plan participant, you are required to:

- Cooperate with the Plan's efforts to ensure a successful subrogation or recovery claim, including setting funds aside in a particular account. This also includes doing nothing to prejudice the Plan's subrogation or recovery rights outlined in this Summary;

- Notify the Plan within 30 days of the date any notice is given by any party, including an attorney, of your intent to pursue or investigate a claim to recover damages or obtain compensation due to sustained injuries or illness; and

- Provide all information requested by the Plan, the Claims Administrator or their representatives, or the Plan Administrator or its representatives.

The Plan may terminate your Plan participation, offset your future benefits or use other measures in the event that you fail to provide the information, authorizations, or to otherwise cooperate in a manner that the Plan considers necessary to exercise its rights or privileges under the Plan.

If the subrogation provisions in these "Acts of third party" provisions conflict with subrogation provisions in an insurance contract governing benefits at issue, the subrogation provisions in the insurance contract will govern. If the right of recovery provisions in these "Acts of third party" provisions conflict with right of recovery provisions in an insurance contract governing benefits at issue, the right of recovery provisions in the insurance contract will govern.

Occasionally, benefits are paid under the Health Coverage of the Plan for charges Incurred by the Member as a result of Injury or disease. If this happens, the Plan is subrogated, unless otherwise prohibited by law, to the rights of recovery that the Member may have against any person or organization who may acknowledge liability or be found liable by a court of competent jurisdiction for the Injury or disease.

The Member will be required to reimburse the Plan out of any monies the Employee or the Dependent receives from any other person or organization as a result of judgment, settlement, or otherwise. Neither the Employee nor the covered Dependent will be required to reimburse the Plan more than the amount the Member or the Dependent recovers for the Injury or disease.

The Member has the obligation to cooperate with the Plan in recovering any amounts owed to the Plan under these subrogation provisions. In the event the Member shall fail to cooperate, the Member shall be liable to reimburse the Plan for all amounts for which a third party may be liable and shall forfeit the right to receive further benefits in regard to Injury or disease.

Subrogation rights apply only to the extent that benefits are paid under the Health Coverage of the Plan. Any fees and costs associated with the recovery shall be borne by the Plan Administrator.

The State of South Dakota also reserves the right to pursue recovery from the third party at its discretion should the Member decide not to attempt recovery. The Member must notify the Bureau of Human Resources, Benefits Program, or the Claims Administrator immediately about any Injury or illness that may have been caused by a liable third party.