CLAIMS PAYMENT PROCESS

A claim for benefits must be made to the Plan Administrator in writing within one year after the end of the Plan Year in which the charges are Incurred. A written claim must include the following information:

(a) Date of service;

(b) Insurance coding (procedure CPT code, diagnosis code);

(c) Provider tax ID number;

(d) Policy holder information;

(e) Patient name, ID number, and date of birth; and

(f) Cost of the procedure(s) or service(s) performed.

Failure to furnish proof of the service received within the time limit may not result in denial or reduction of a claim if it is shown:

(a) It was not reasonably possible to provide the proof within the time limit that applies; and

(b) Proof was provided as soon as reasonably possible.

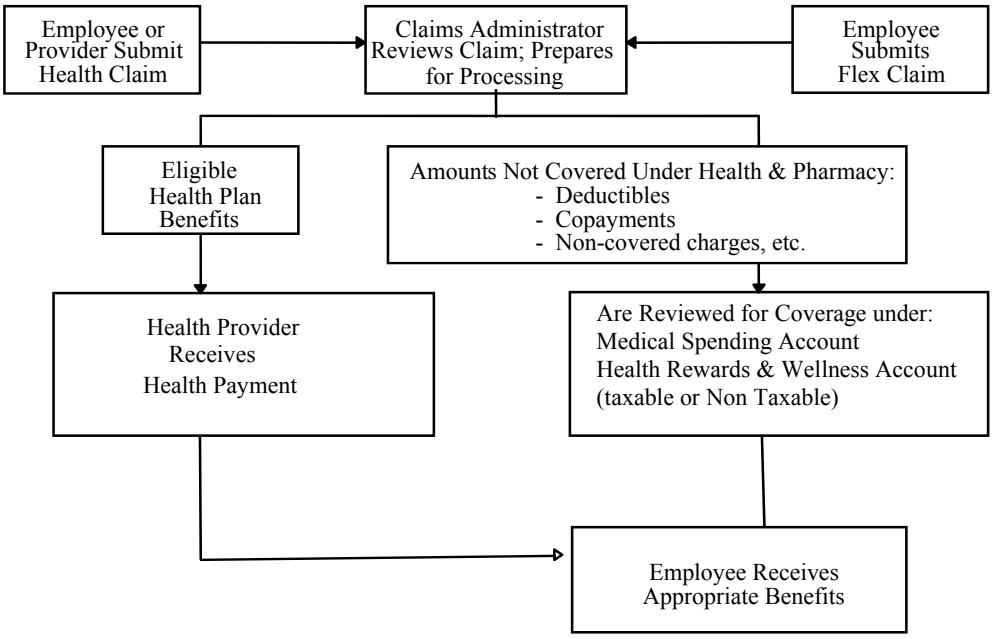
Approval for processing must be obtained from the Bureau of Human Resources. Upon completion, members should receive an Explanation of Benefits (EOB).

Members are encouraged to examine Hospital and doctor bills for accuracy to ensure services are received for charged amounts. Member should also review any Explanation of Benefits (EOB) received from DAKOTACARE for possible processing errors.

ONE-STOP CLAIMS PROCESSING

"One-stop" claims processing applies to most health and flexible benefit claims. As shown in the following chart, the Health Plan Claims Administrator will check health and flexible benefit claims to see if they may also be eligible for coverage under most of the other State plans. This is an automatic process. Employees will not have to turn in separate claims to each Plan to receive benefits. See "Processing Exceptions".

AUTOMATIC CLAIMS PAYMENT PROCESS



Claims will not go through this automatic process in certain circumstances. See the exceptions below for details.

PROCESSING EXCEPTIONS

The one-stop process will not apply, and Employees must submit separate claims to the plans that apply, in the following situations:

- The Employee sends the Bureau of Human Resources a written request to stop the automatic claims processing. Requests to the stop automatic claims processing affects benefits of all family members: Employee, spouse, and Dependents.

- Dependent Care/ Day Care Spending Account claims.

- Dual Health Coverage under more than one plan. If the Member is covered by more than one health plan, the Health Plan Claims Administrator will process health claims. Members will have to submit separate claims and required documentation to each plan that applies after receiving their Explanation of Benefits from the other health plan.

- The Employee and spouse both work for the State of South Dakota and one is covered under the other's flex plan(s).

- Election to tax the Health Rewards and Wellness Account (HRWA) and wish to be reimbursed for non-medical related expenses such as exercise equipment or nutrition and fitness centers fees.

BENEFIT PAYMENTS

Upon receipt by the Plan Administrator of a claim, benefits under the Plan are paid as follows:

(a) The Plan Administrator may elect to pay the benefits directly to the Hospital or other provider. The Plan Administrator reserves the right to refuse assignment of benefits to any provider.

(b) Benefits to which the Employee is entitled which remain unpaid at the Employee's death are paid to the Employee's beneficiary, if a designated beneficiary (spouse and/or other designated Dependent) survives the Employee. Otherwise, the benefits are paid to the Employee's estate.

(c) The Plan Administrator has complete discretion to interpret the provisions of the Plan, make findings of fact and assign benefit payments. Decisions by the Plan Administrator will be final and binding on Plan Members, subject to a grievance on the Employee's part to challenge denials. See "Appealing a Denied Claim" for information about the grievance procedure.

PHYSICAL EXAMS, AUTOPSY, SECOND OPINIONS, AND RELEASE OF INFORMATION

The Plan Administrator, at its own expense, may require the person whose Injury, disease, or condition is the basis of a claim be examined by a Physician chosen by it. The Plan Administrator may require an exam as often as is reasonable while a claim is pending. In case of death, it may require an autopsy where the law does not forbid it to do so.

The South Dakota State Employee Health Plan covers Physician consultation services when Incurred as a result of voluntary second surgical opinions or other requirements of the Managed Care Program. Voluntary second opinions are subject to the same Deductible, Copayments, and Coinsurance provisions that apply for any other surgical or medical procedures under the Plan. The Plan Administrator may require second opinions for certain covered services and for surgical procedures that must be redone because the Patient did not follow Physician instructions. See "Services Requiring Second Opinions".

The Employee is responsible for providing the Plan Administrator or the Claims Administrator with the information needed to administer the Plan and to process and pay claims. For example, to Opt-Out of coverage under this Plan, the Employee must provide a signed letter from the other group health plan stating that he or she has coverage elsewhere. To ensure proper coordination of benefits, the Employee must provide an Explanation of Benefits for any benefits paid by another group health plan. In addition, by enrolling and participating in the Plan, the Employee agrees to cooperate in claims audits and agrees that the Plan Administrator has the right to contact any other organization or person whenever necessary to obtain additional information about a claim.

CLAIMS ADMINISTRATOR'S RIGHT TO INVESTIGATE CLAIMS

By submitting a claim for benefits or reimbursement, the covered Member is certifying the information on the claim form is true and complete to the best of his or her knowledge and belief.

The covered Member is also agreeing that the Plan Administrator and/or Claims Administrator have the right to investigate the claim, if necessary, or to contact any other organization or persons to obtain additional information about the claim. This investigation may be conducted prospectively or retrospectively.

The claim will be denied if the covered Member misrepresents, falsifies, or omits information necessary to process the claim.

BILLING AND PROCESSING ERROR INCENTIVE PROGRAM

Members are encouraged to examine Hospital and doctor bills for accuracy to ensure services are received for charged amounts. Member should also review any Explanation of Benefits (EOB) received from DAKOTACARE for possible processing errors.

If an error is found on a bill or EOB, the Plan will pay the Member 50% of the money saved by the Plan. The minimum savings to the Plan to qualify for a payment is $50. The maximum payment is $1,000 per medical occurrence.

When reviewing Hospital or doctor bills, keep in mind that this incentive applies only to covered charges for inpatient Hospital care, outpatient surgery in an ambulatory care facility, or services received from clinics and related tests. It applies to any processing errors found on an EOB.

Member is responsible for:

- Auditing charges and EOB payments;
- Requesting corrected billings from providers or corrected EOB from DAKOTACARE; and
- Submitting all documentation to the Bureau of Human Resources for processing.

Documentation required for Bureau of Human Resources:

- Copy of the incorrect bill or EOB;
- Corrected bill or EOB; and
- Brief explanation of the error.

NOTE: With Diagnostic Related Group (DRG) based billing; itemized charges do not affect the Hospital bill. Therefore, the billing error incentive does not apply to these Hospital bills.