WORDS AND PHRASES

Some terms used in the Plan are defined below. Other terms may be explained where used in another part of the Plan.

(a) **"Acute Rehabilitation Facility" -** An institution operated pursuant to law for the purpose of providing Rehabilitation Therapy.

(b) **"Accidental Injury of Injury" –** Some type of bodily harm sustained in an accident during the period of coverage.

(c) **"Annual Enrollment Period" -** The period before the beginning of a Plan Year when State Employees may elect coverage, change Plans, or make other changes to the existing healthcare coverage. See "Late Entrants" or "Special Enrollment" for information about existing State Employees adding a Spouse and Dependents coverage during the Annual Enrollment Period.

(d) **"Allowed Amount" –** Maximum amount on which payment is based for covered health care services. This may be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference (See Balance Billing).

(e) **"Appeal" -** A request for your health insurer or plan to review a decision or a grievance again.

(f) **"Approved Clinical Trial" –** A clinical trial that is being conducted in relation to the prevention, diagnostic or treatment of cancer or other life-threatening diseases or conditions. The clinical trial must be approved or sponsored by a health related federal agency.

(g) **"Balance Billing" –** When a provider bills you for the difference between the provider charges and the allowed amount. For example, if a provider charges $100 and the Allowed Amount is $70, the provider may bill you for the remaining $30. A Preferred Provider (DAKOTACARE Network) may not balance bill you for covered services.

(h) **"Benefit Maximum" -** The maximum benefit paid per Member for specific services. See "Master Schedule" and "Benefit Maximum" for listing of services.

(i) **"Biologically-Based Mental Illness" -** 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 to be Biologically-Based Mental Illnesses.

(j) **"Body Mass Index (BMI)" -** A formula that uses weight and height to measure body fat and health risks. A BMI between 18.5 and 24.9 is typically considered a healthy weight range for that individual's height. A BMI between 25 and 29.9 means the individual is considered overweight. And if the figure is 30 or greater, the individual is considered obese, with an abnormally high proportion of body fat, and should talk with his or her doctor about losing weight to decrease health risks.

(k) **"Chiropractor"** – A chiropractic Physician licensed pursuant to SDCL Chapter 36-5 and who has entered into a service agreement with DAKOTACARE or its designated contractual network.

(l) **"Chiropractic Network" -** A group or groups of chiropractors who the State has designated as participating, or network, providers. Currently, chiropractors participating in the Chiropractic Associates LTD of South Dakota (CASD) network are considered participating providers.

(m) **"Claims Administrator" -** The person or persons designated by the Bureau of Human Resources to receive, process, and determine all claims submitted by Members under this Plan. Currently, DAKOTACARE is the Claims Administrator for the South Dakota State Employee Health Plan.

(n) **"COBRA"** – The Consolidated Omnibus Reconciliation Act of 1985 and amended thereafter.

(o) **"Coinsurance"** – Your share of the costs of covered health care service, calculated as a percentage (for example, 25%) of the allowed amount for the service. You pay Coinsurance plus any Deductibles you owe.

(p) **"Copayments" or "Copays"** – A fixed amount (for example, $15) you pay for a covered health care service, usually when you receive the service. The amount can vary by the type of covered health care service.

(q) **"Coordination of Benefits"** – A provision establishing an order in which plan pays their claims, and permitting secondary plans to reduce their benefits so that the combined benefits of all plan do not exceed total allowable expense.

(r) **"Creditable Coverage"** – Defined in SDCL 58-17-69, "…benefits or coverage provided under:

1) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan or an employee welfare benefit plan as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 as adopted by the director pursuant to chapter 1-26, to the extent that the plan provides directly or through insurance, reimbursement or otherwise to employees, their spouse or dependents medical care for the diagnosis, cure, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body and amounts paid for the transportation primarily for and essential to medical care;

2) An individual health benefit plan, including coverage issued by any health maintenance organization or pre-paid hospital or medical services plan that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan as approved pursuant to chapter 1-26, but excluding limited benefit plans and dread disease plans;

3) Medicare or Medicaid;

4) Chapter 55 of Title 10, U.S.C.;

5) A medical care program of the Indian Health Service or of a tribal organization;

6) A state health benefits risk pool;

7) A health plan offered under Chapter 89 of Title 5, U.S.C.;

8) A public health plan;

9) A health benefit plan under Section 5(e) of the Peace Corps Act 22 U.S.C. 2504(e);

10) A church plan;

11) A college plan;

12) A short term or limited duration plan; or

13) An individual health benefit plan, including coverage issued by any health maintenance organization or pre-paid hospital or medical services plan that provided benefits less than the benefits provided under the basic health benefit plan as approved pursuant to chapter 1-26, but excluding the following excepted benefits:

(a) Coverage only for accident including accidental death and dismemberment;

(b) Disability income insurance;

(c) Liability insurance including general liability insurance and automobile liability insurance;

(d) Coverage issued as a supplement to liability insurance;

(e) Workers' compensation or similar insurance;

(f) Automobile medical payment insurance;

(g) Credit only insurance including mortgage insurance;

(h) Coverage for on-site medical clinics; and

(i) Limited scope dental and long-term care insurance, if provided under a separate policy, certificate, or contract of insurance, or not otherwise an integral part of a plan.

(s) **"Custodial Care"** - A level of care which:

1) Cannot reasonably be expected to greatly restore health;

2) Is mainly made up of non-skilled nursing services; and

3) Is chiefly designed to assist a person in coping with the activities or problems of daily living - such as training or assistance with personal hygiene and other self-care activities. (Custodial care may be given in an at-home setting or in a nursing home or Extended Care Facility.)

(t) **"Deductible"** – The amount you owe for health care services your health insurance or plan covers before your health insurance or plan begins to pay. For example, if your Deductible is $1,250, your plan won't pay anything until you've met your $1,250 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.

(u) **"Dependent"** - Means the following, as long as such person is not otherwise eligible to be covered as an Employee under the Plan; or, if such person was previously eligible, is no longer eligible because of a disability:

1) Each of the Employee's children who is:

   a) Under the age of 26 or under the age of 29 if a Full-Time Student. For purposes of life Coverage, benefits shall cease for a Dependent Child on the last day of the month in which each child attains age 26, or age 29 if a Full-Time Student if applicable premium is paid; or

   b) Not in military service.

The term "children" means children by birth, adopted children, children who have been placed for adoption, stepchildren, or children who live with the Employee in a legal parent-child relationship (legal guardianship).

Newborn children of an employee may be covered at birth provided the Plan is notified within 60 days of the birth and the appropriate premium is paid.

Notwithstanding the above, "Dependent" also includes an eligible Employee's child named as an alternate recipient with respect to such Eligible Employee under a Qualified Medical Child Support Order (QMCSO) (as defined in ERISA Section 609(a)(2)(A)).

(v) **"DRG (Diagnosis-Related Group)"** - A Hospital reimbursement system first implemented by the Medicare program. The reimbursement amount typically is based on a pre-determined classification of diagnoses, treatments, age, sex, and discharge status of Patients. Under the South Dakota State Employee Health Plan, this pre-determined rate of reimbursement is based on an average cost for a service and agreed to by the provider and the State. Also called "Diagnostic Related Group."

(w) **"DRG Payment Method"** - An approach that bases payment for acute Hospital inpatient services on the DRG system of classifying Patients.

(x) **"Drug Formulary"** – A compilation of therapeutically effective prescription drugs that are accepted by the South Dakota State Employee Health Plan for treatment of Members. Within a particular therapeutic category, some, but not all brand-name and generic drugs may be included. The prescription medications, which are included on the Drug Formulary, may be amended by the South Dakota State Employee Health Plan at any time without notice to the Member. To view the formulary, visit http://benefits.sd.gov/Forms.aspx and click FY15 Formulary located in the Pharmacy section.

(y) **"Durable Medical Equipment (DME)"** – Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include but are not limited to: oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.

(z) **"Eligible Employee"** – An active Employee placed in a permanent position, employed by a participating agency and scheduled to work 20 or more hours a week at least six months of the year.

(aa) **"Emergency Services" -** Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

(bb) **"Enrollment Date" –** The first day of coverage, or if there is a waiting period, the first day of the waiting period.

(cc) **"ERISA" –** The Employee Retirement Security Income Act of 1974 and amendments thereto.

(dd) **"Experimental Investigational Treatment" -** A drug, medicine, device, medical technology, medical treatment, or procedure that meets one or more of the following criteria:

1) A drug, medicine, or device which cannot be lawfully marketed without approval of the United States Food and Drug Administration and approval of marketing has been given at the time the drug or medicine or device is furnished; or

2) Impact(s) of drug or medicine, device, or medical treatment are not known. Sufficient data is not available at the time of determination on the likely net health impacts of the drug or medicine, device, or medical treatment requested. Sufficient data means:
    a) Evidence including published reports and articles in authoritative, peer reviewed medical and scientific literature;

    b) A written informed consent used by the treating facility or by another facility studying substantially the same service, device, or drug; or

    c) A written protocol or protocols used by the treating facility or protocols of another facility studying substantially the same service, device, or drug.

3) A drug, medicine, device, medical technology, medical treatment, or procedure which has not been approved by the Plan.

(ee) **"Extended Care Facility (ECF)" -** An institution, which:

1) Is operated pursuant to law;

2) Is approved as a skilled nursing facility for payment of Medicare benefits or qualified to receive that approval, if requested;

3) Is primarily engaged in providing room and board and skilled nursing care under supervision of a Physician;

4) Provides continuous 24 hour a day skilled nursing care by or under supervision of a registered nurse (RN); and

5) Maintains a daily medical record of each Patient.

Coverage under this Plan at an ECF is limited to sixty (60) days per Plan Year.

A home, facility, or part of a facility does not qualify as an ECF if it is used primarily for:

1) Rest;

2) The care of drug abuse or alcoholism;

3) The care of mental diseases or disorders; or

4) Custodial or educational care.

(ff) **"FMLA"** – The Family Medical Leave Act of 1993 and amendments thereto.

(gg) **"Flexible Spending Account (FSA)" –** An account that allows an employee to set aside a portion of earnings to pay for qualified expenses as outlined by the IRS Section 125- most commonly for medical expenses and dependent care/day care expenses.

(hh) **"Full Time Student" –** Full time status is defined by each higher education institution. Example: A Dependent taking 12 credits as an undergraduate, 9 credits as a graduate, or considered a Full-Time Student by the educational institution.

If ineligible, the Dependent must be removed from the plan. Example of removal dates:

1) Graduation: End of the month in which graduation occurs;
2) Cease full-time status mid-year: End of the month in which last a full-time student;
3) Student verification not received for Spring semester: End of the month in which the last a Full-Time Student, example December 31; and
4) Student verification not received for fall semester: End of the month in which last a full-time student, example May 31.

Note: Coverage is not lost during summer months, if student status continues from spring to fall semester.

(ii) **"GINA"** – Genetic Information Nondiscrimination Act of 2008 and amendments thereto.

(jj) **"Health Coverage" -** All coverage available under the South Dakota State Employee Health Plan.

(kk) **"Health Savings Account (HSA)"** – An account that enables you to pay for covered medical expenses with pretax dollars. The contributions you and the State make to the HSA grow with interest over time and can be taken with you when you retire or if you terminate employment with the State. Contributions, earnings and withdrawals, when used for qualifying medical care, are all tax-free.

(ll) **"HIPAA"** – The Health Insurance Portability and Accountability Act of 1996 and amendments thereto.

(mm) **"Home Health Agency" -** Means:

1) An agency licensed as a Home Health Agency by the State in which home healthcare services are provided; or

2) An agency certified as such under Medicare; or

3) An agency approved as such by the Plan Administrator.

(nn) **"Home Health Care"** – Health care services a person received at home.

(oo) **"Hospice"** – A facility or program engaged in providing palliative and supportive care of the terminally ill.

(pp) **"Hospital"** - An institution which:

1) Is operated pursuant to law for the provision of medical care;

2) Provides continuous 24 hour a day nursing care under the supervision of a staff of Physicians;

3) Has facilities for providing diagnostic and therapeutic services to diagnose, treat, and care for injured, disabled, or sick individuals who need acute inpatient care;

4) Has facilities for major surgery; and

5) If required, is licensed as a Hospital.

But, an institution primarily concerned with the treatment of chronic disease does not need to have facilities for major surgery, if it otherwise qualifies, as provided above.

"Hospital" also means an ambulatory surgical center, which is operated pursuant to law, including licensed mobile units.

For treatment of alcoholism and drug abuse only, "Hospital" also means:

1) A treatment or residential facility; or

2) A clinic.

Such facilities must be licensed or approved by the appropriate authority for these purposes in the jurisdiction in which they are located.

"Hospital" does not include a:

1) Rest home;

2) Nursing home;

3) Convalescent home;

4) Place for Custodial Care;

5) Home for the aged;

6) Institution that primarily furnishes training for medical students; or

7) A Doctor's office or clinic, which is equipped to perform minor surgery.

(qq) **"Hospital Admission"** - Entering a Hospital as an inpatient and incurring a room and board charge, whether for observation or treatment. Each admission to a Hospital will be deemed a

separate Hospital Admission, unless the Patient is readmitted to the Hospital for the same condition within 7 days. If readmitted within this timeframe, only one Deductible or facility Copayment will apply.

(rr) **"Hospital Stay"** - If a person:

1) Incurs a Hospital room and board charge for Medically Necessary inpatient care, whether for observation or treatment;

2) Receives emergency care at a Hospital for an Injury not later than 72 hours after the onset of the Medical Emergency or the Injury occurs;

3) Undergoes surgery at a Hospital; or

4) Treatment for alcoholism or drug abuse at a Hospital.

Unless it is an emergency or a "normal" maternity admission, inpatient Hospital stays must be pre-authorized by HMP before the Patient is Hospitalized.

(ss) **"Incapacitated Dependent"** – An Incapacitated Dependent must:

1) Be incapable of self-support because of intellectual disability or any other mental or physical disability;

2) Become incapacitated prior to attaining the limiting age for coverage of children; and

3) Remain Dependent upon the insured parent or guardian for support and maintenance (meets the Internal Revenue Service (IRS) requirements for dependents for federal income tax purposes). Refer to website: http://www.irs.gov/publications/p501/ar02.html#d0e853.

(tt) **"Incurred"** - A charge is deemed "Incurred" on the date the service or supply is provided.

(uu) **"Injury"** - Only bodily Injury sustained accidentally by external means.

(vv) **"Late Entrants"** - An Eligible Employee, Spouse or Dependent(s) who request enrollment following the initial enrollment period and who are subject to a waiting period for coverage under the South Dakota State Employee Health Plan. An eligible State Employee may enroll his or her Spouse or Dependent(s) during an Annual Enrollment Period without an associated qualified family status change event. One of the following circumstances may apply:

1) A new State Employee fails to enroll eligible Spouse or Dependent(s) in the South Dakota State Employee Health Plan within 30 days after his or her date of hire;

2) An existing State Employee fails to apply for a qualified family status change within 60 days of the event;

3) An existing State Employee who "Opts-Out" of the South Dakota State Employee Health Plan coverage and then fails to enroll or re-enroll Spouse or Dependent(s) within 63 days after involuntarily losing other group Health Coverage, or

4) An existing State Employee who "Opts-Out" of the South Dakota State Employee Health Plan coverage then voluntarily loses his other health plan coverage, any Spouse or Dependent(s) he or she tries to enroll or re-enroll in the South Dakota State Employee Health Plan. See "Special Enrollment" for exceptions to "Late Entrants."

(ww) **"Legal Guardian"** – A person appointed by a court to be responsible for the personal affairs of a minor or protected person.

(xx) **"Locality"** - A county or such greater area as is needed to establish a representative cross section of providers who regularly furnish the type of service or supply for which the charge is made.

(yy) **"Maximum Allowable Charge (MAC)"** - The charge a provider agrees to accept, in lieu of the usual, reasonable, and customary charge, as a condition of becoming a participating network provider. Employees should not be billed for more than the "Maximum Allowable Charge" by a participating provider.

(zz) **"Medical Emergency"** - A sudden and unexpected onset of a medical condition causing the person to seek medical care and treatment promptly or within a reasonable time after the onset.

(aaa) **"Medical Support Order"** - Any judgment, decree or order, including a court approved settlement agreement, issued by a domestic relations court or other court of competent jurisdiction, or through an administrative process established under state law which has the force and effect of law in that state, and which assigns to a child the right to receive health benefits for which a Member is eligible under the Plan, and that the Plan Administrator determines qualified under the terms of ERISA and applicable state law. Children who may be covered under a medical support order include children born out of wedlock, those not claimed as dependents on the Employee's Federal income tax return, and those who don't reside with the Employee. However, children who are no longer eligible, due to their age for example, cannot be added under a medical support order. A typical reason courts or certain administrative agencies issue a medical support order is to protect the benefit coverage of children in cases of divorce.

The Employee or Member will be notified if the State receives a medical support order affects him or her. If the Employee receives a medical support order, he or she should contact the Bureau of Human Resources. They will then follow the necessary administrative procedures. This will ensure compliance in determining the status of the medical support order.

Also known as a "Qualified Medical Child Support Order" or "ordered medical support coverage".

(bbb) **"Medically Necessary"** – Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms and that meet accepted standards of medicine.

(ccc) **"Member"** – Any Employee, Spouse or Dependent who is insured under the Plan.

(ddd) **"Morbid Obesity"** - The point at which there is immediate health risks from the condition of obesity. This includes the likelihood of developing a number of potentially serious health problems such as hypertension (high blood pressure), diabetes, coronary artery disease, stroke, or severe joint disease. Under this Plan, a covered individual must also have a BMI of 40 or greater to be considered morbidly obese.

(eee) **"Non-Emergency Services" -** A Hospital Admission or medical treatment that is not an emergency admission.

(fff) **"Occupational Disease" -** A disease for which a person is entitled to benefits under a Workers' Compensation Law or similar law.

(ggg) **"Occupational Injury" -** An Injury which arises out of and in the course of employment for wage or profit. An Injury will not be deemed occupational if such person is not eligible for Workers' Compensation coverage.

(hhh) **"Office Visit" –** Covered Physician services when provided in the Physician's office setting.

(iii) **"Out-of-Pocket Maximum" –** The portion of payments for health services which is the responsibility of the Member, which shall include Deductible and Coinsurance.

(jjj) **"Patient" -** Any Employee, Spouse or Dependent who is insured under the Plan and to whom the Managed Care Program applies.

(kkk) **"PPACA" -** Patient Protection and Affordable Care Act of 2010 and amendments thereto.

(lll) **"Patient's Representative," –**

1) Patient's relative, friend, or guardian;

2) Patient's Physician; or

3) A representative from an institution providing care to the Patient.

(mmm) **"Pharmacy Network" -** A group or groups of pharmacies who have contracted with the State to provide services to Plan Members and who the State has designated as participating, or network, providers. Currently, pharmacies participating in the CVS Caremark Pharmacy Network are considered participating pharmacies.

(nnn) **"Physician" -** One who is licensed as such while acting within the scope of that license. The following licensed practitioners shall be considered "Physicians":

1) Doctor of Chiropractic (D.C.);
2) Doctor of Dental Surgery (D.D.S.);
3) Doctor of Medicine (M.D.);
4) Doctor of Ophthalmology (M.D.);
5) Doctor of Optometry (O.D.);
6) Doctor of Osteopathy (D.O.);
7) Doctor of Podiatry (D.P.M.);
8) Doctor of Psychiatry (M.D.): and
9) Doctor of Psychology (Ph.D.).

"Physician" also includes spiritual healers, Certified Social Workers (CSW), Social Workers (SW), and Social Worker Associates (SWA) who have the Private Independent Practice (PIP) designation.

(ooo) **"Pre-authorization"** –A decision by your health insurer or plan that a health care service, treatment plan, prescription drug, or Durable Medical Equipment is medically necessary. Sometimes called prior authorization, prior approval, or precertification. Your health insurance or plan may require Pre-authorization for certain services before you receive them, except in an emergency. Pre-authorization isn't a promise your health insurance or plan will cover the cost.

(ppp) **"Preventive Care"** – Care received to prevent illness and disease. Preventive Care includes things such as routine cancer screenings, well-child care, and immunizations.

(qqq) **"Pregnancy"** - The condition of being pregnant and childbirth as well as related medical conditions.

(rrr) **"Primary Care Provider"** - A physician (M.D.-Medical Doctor or D.O. Doctor of Osteopathic Medicine), nurse practioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

(sss) **"Qualified Domestic Relations Order (QDRO)" –** A Qualified Domestic Relation Order is a domestic relations order that creates or recognizes the existence of an alternate payee's right to receive, or assigns to an alternate payee the right to receive, all or a portion of the benefits payable with respect to a Member under a retirement plan, and that includes certain information and meets certain other requirements.

(ttt) **"Qualified Medical Child Support Order (QMCSO)"** - A Qualified Medical Child Support Order is a court order used to enforce an order for a health plan Member to provide child support health benefits. It requires a health plan to include a child as covered under a health plan, even if the child(ren) or the Member do not meet the conditions of the health plan. A QMSCO is typically used to gain coverage for a child under a non-custodial parent's group health plan. It is normally obtained by a divorced or separated spouse or by a state child support or Medicaid agency. The order authorizes withholding the Member's share of the cost for coverage from their pay. They may not drop coverage for the child without proof that the QMSCO is no longer in effect.

(uuu) **"Qualified Mental Health Professional (QMHP)"** - A Qualified Mental Health Professional (QMHP) is a professional "endorsed by the South Dakota Department of Human Services (SDCL 27A-1-7). Only a QMHP may do the examination required as part of an involuntary mental illness commitment process (27A-10-6). Physicians licensed pursuant to SDCL 36-4 are considered Qualified Mental Health Professionals and are not required to receive the endorsement. Individuals eligible for endorsement are those listed in SDCL 27A-1-3:

- A psychologist who is licensed to practice psychology in the state where services are received;
- A psychiatric nurse with a master's degree from an accredited training program and two years of supervised clinical experience in a mental health setting;
- A certified social worker with a master's degree from an accredited training program and two years of supervised clinical experience in a mental health setting;
- A person who has a master's degree in psychology from an accredited program and two years of supervised clinical mental health experience and who meets the provision of Subdivision 36-27A-2 (2); or
- A counselor who is certified under SDCL chapter 36-32 as a licensed professional counselor-mental health (LPC-MH).

(vvv) **"Quantity Level Limit (QLL)"** – The maximum dosage of units supplied of a prescription medication that a Member may receive at one time based on recognized standards of safety and clinical dosing guidelines.

(www) **"Rehabilitation Therapy"** - A series of procedures or treatments provided in a Hospital, Extended Care Facility (ECF) or Acute Rehabilitation Facility, which will enable an injured or ill person to carry on the regular and customary activities of a person of the same age and sex.

(xxx) **"Retired Employee"** - A former Employee who is covered under the Health Coverage plan provided under SDCL 3-12A on his or her date of retirement. The Retired Employee must also be entitled to immediate retirement benefits as a Class A or Class B member of the South Dakota Retirement System or the South Dakota Department of Labor Retirement Plan as outlined in SDCL 3-12-91, SDCL 3-12-92 and SDCL 61-2-15.

Medicare is primary to the State Plan for retired Members and spouses. Medical coverage under this Plan ends the first of the month in which the retired Member and/or his or her spouse turn age 65. At that time coverage may be converted to a Medicare Supplement Plan.

(yyy) **"SDCL"** – South Dakota Codified Laws.

(zzz) **"Significant Impairment of Function"** - A mental or nervous condition that creates significantly increased risk of suffering death, pain, disability, or an important loss of freedom. This would include a person who, as a result of mental illness:

1) Is in danger of serious physical harm due to the inability to provide essential human needs for food, clothing, shelter, or medical care;

2) Lacks judgment in the management of resources and in the conduct of social relations to the extent that health or safety is significantly endangered; or

3) Needs continued therapeutic treatment and support in order to maintain functioning above the levels noted above.

(aaaa) **"Special Enrollment Period"** – A period made available to an Eligible Employee, his/her spouse, and or dependents who have previously declined coverage in writing stating that the employee, spouse and or dependents had other health insurance coverage at the time of initial eligibility. The Special Enrollment Period applies when the employee, spouse or Dependent was:

1) Covered under other Creditable Coverage at the time of the initial eligibility, and

2) The previous coverage is either:

   i) Continuation coverage that is exhausted; or

   ii) Other Creditable Coverage is terminated due to loss of eligibility or termination of employer contributions to the coverage.

A request for participation under this clause must be made within sixty-three (63) days of the date of termination of the previous coverage.

A Special Enrollment Period is also available to a new Spouse or Dependent as a result of marriage, birth, adoption, or placement for adoption. You may be able to enroll your Spouse and or dependents, provided you request enrollment within 60 days of the event. See "Late Entrants" for situations in which Special Enrollment does not apply.

(bbbb) **"Specialty Injectable Medication"** – High-cost, biotech drugs used to treat long-term or chronic diseases, which are administered by subcutaneous injection, intramuscular injection, or intravenous infusion.

(cccc) **"Specialty Medications"** – Scientifically engineered medications that are prescribed to Patients with complex diseases that may include rheumatoid arthritis, growth deficiencies, multiple sclerosis, or cancer. The medications tend to be the product of innovative technology, high cost, and require special handling and administration. Types of specialty medications may include, but are not limited to: self-administered injectable drugs administered by the Patient or the Patient's caregiver in a home setting; office-administered injectable drugs administered by a healthcare professional in non-Hospital setting; inhalation agents for non-cancer treatments; and high cost oral agents.

(dddd) **"Spouse"** – An Employee's husband or wife as a result of marriage that is legally recognized in South Dakota. The Spouse in a common-law marriage is not eligible to be covered on the plan.

(eeee) **"Surgical Procedure"**

1) A cutting procedure;

2) Suturing of a wound;

3) Treatment of a fracture;

4) Reduction of a dislocation;

5) Radiotherapy, excluding radioactive isotope therapy, if used in lieu of a cutting operation for removal of a tumor;

6) Electrocauterization;

7) Diagnostic and therapeutic endoscopic procedures; and

8) An operation by means of laser beam.

(ffff) **"Tier 1"** – Tier 1 is a benefit for all covered members of the health plan that will reduce the cost associated with certain cardiac, orthopedic, bariatric, renal care and gastroenterology services. 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 and providers will provide high quality care at a set rate for provider, anesthesia, lab work, pathology, and x-ray services for a Tier 1 service. The services a member receives at a Tier 1 facility three days prior and 30 days after the procedure are covered at a set rate. In cases of a Tier 1 Bariatric procedure the set rate for services is a 365 day period.

(gggg) **"Usual, Customary and Reasonable (UCR)"** – The amount paid for a medical service in geographic area based on what providers in the area usually charge for the same or similar medical service. The UCR amount sometimes is used to determine the allowed amount.

(hhhh) **"Utilization Review Organization (Health Care Management Company)"** - The independent entity, group, or individual selected by the Bureau of Human Resources to carry out the State Managed Care Program. Currently, Health Management Partners (HMP) is the State Health Care Management Company and Utilization Review Organization for medical services, treatment, and supplies. At its discretion, the State may designate some other company to perform this function.

(iiii) **"Written Notice"** - A notice in writing on a form supplied by or which satisfies the Plan Administrator.