

South Dakota State Employee Health Plan

SUMMARY PLAN DESCRIPTION DOCUMENT

**FY14
Health Plan**

The description in this Summary Plan Description Document does not imply that you have enrolled in these Plans. Your enrollment in any or all of these benefits is determined by records maintained by the Bureau of Human Resources. As Plan Administrator, the Bureau of Human Resources has final authority to make determinations on eligibility, enrollment and issues not specifically addressed in Plan provisions, ambiguously written provisions, or verbal representations that appear to conflict with any section of this official Summary Plan Description Document. The information contained in this Summary Plan Description Document and its interpretation by the Plan Administrator (the Bureau of Human Resources) or the Plan Administrator's designee supersedes all verbal representations of the Plan provisions and will govern in all cases.

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MASTER SCHEDULE

South Dakota State Employee Health Plan (Administered by the Commissioner of the Bureau of Human Resources of the State of South Dakota)

Effective Date:	July 1, 2013
Eligible Class:	All Full-Time Employees, Eligible Retirees under age 65, and COBRA Members, as determined by the State of South Dakota.
Waiting Period:	One month and one day from the date of hire.
Eligible Dependents:	Spouse and Dependent Children meeting certain requirements.
Use of Social Security Numbers:	<p>Please note the following important information about the use of Members Social Security numbers. Federal law (Title XI, Section 1144 of the Social Security Act, Medicare - Medicaid Coverage Data Bank) requires the use of Members tax identification numbers (or Social Security numbers) to identify Members under the South Dakota State Employee Health Plan. Under this law, each year the State must provide the Centers for Medicare and Medicaid Services (CMS) a list of the individuals covered under the South Dakota State Employee Health Plan. CMS uses this information to determine if Medicare recipients have primary healthcare coverage elsewhere. This group was formerly known as the Health Care Financing Administration (HCFA).</p> <p>The required list includes all Plan Members.</p> <p>The South Dakota State Employee Health Plan assigns random identification (ID) numbers, which are printed on the Member's State Health ID card.</p>
Self-Insurance:	<p>Self-insurance is a method of insuring a large group of employees. The South Dakota State Employee Health Plan became self-insured in 1991. It was determined to be the least costly and most efficient way to make a health plan available to State Employees and their families. The Bureau of Human Resources administers the South Dakota State Employee Health Plan. One of the responsibilities of the Plan Administrator is to hire companies with expertise, manpower, and computer systems to enhance benefits and quality of service for Members.</p> <p>The South Dakota State Employee Health Plan uses several vendors that are called "third party administrators." Vendors provide only administrative services. The vendors do not assume any financial risk or obligation with respect to claims. Financial risks taken and the obligation to pay claims are the responsibility of the self-insured</p>

South Dakota State Employee Health Plan, which is funded through a combination of State dollars and Employee contributions.

Grandfathered Status:

The South Dakota State Employee Health Plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic Health Coverage that was already in effect when that law was enacted. Being a grandfathered health plan means this plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

State Benefit Philosophy:

The South Dakota State Benefit Plans are “self-insured” plans. Everyone participating in a Plan is a “stakeholder,” with a personal stake in Plan costs, contribution levels, and benefit coverage.

State:

- Work with Providers to offer comprehensive coverage to Eligible Employees, Retired Employees, and COBRA Members.
- Provide tools and resources to support good health for Members.
- Coordinate with Third Party Administrators.

Members:

- Understand plan options.
- Make informed decisions.
- Maintain good health.

Provider:

- Provide high-quality, competitively priced programs, and service.

Working together to make educated and healthier choices will ensure higher quality care and cost savings for Members.

How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information

Our Legal Duty

For Members in the South Dakota State Employee Health Plan, the Plan is required to provide this Notice of Health Privacy Practices and explain rights and legal duties of the Plan concerning your medical information under Federal law. The Notice of Privacy Practices is located at <http://benefits.sd.gov>, Forms and Documents, and click on [HIPAA Privacy Notice](#). The Plan must follow the privacy practices, which are described in this notice, effective on April 14, 2003, and revised on March 31, 2006.

The State reserves the right to change privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. The State reserves the right to make changes in privacy practices and the new terms effective for all medical information maintained, including medical information created or received before making the changes. Before making a significant change in privacy practices, the State will change this notice and send the new notice to the health plan contract holders.

How the Plan Uses and Discloses Healthcare Information

The Plan provides some services through contracts with private vendors. For example, DAKOTACARE administers most medical claims to healthcare providers. When services are contracted, the Plan may disclose Members information to the vendor so the job can be performed as requested by the Plan. To protect information, the Plan requires the vendors to safeguard information in accordance with the law.

The following categories describe different ways the Plan uses and discloses your health information. Each category is explained below.

- **For payment:** The Plan may use and disclose information in order to authorize payment for the health services received. For example, when receiving a service covered by the Plan, healthcare providers send a claim for payment to the Claims Administrator. The claim includes information, which identifies Members, diagnoses, and treatments.
- **For medical treatment:** The Plan may use or disclose information to ensure Members receive necessary medical treatment and services.
- **To operate various Plan programs:** The Plan may use or disclose information to run various programs and ensure quality care. For example, the Plan may contract with a vendor that reviews Hospital records to check on the quality of care received and the outcome of care.
- **To other government agencies providing benefits or services:** The Plan may provide information to other government agencies that are providing benefits or services. The information will be shared only if necessary to receive those benefits and services.

- **To keep you informed:** The Plan may mail or email information to Members regarding health and well-being. This may include personal information, managed care choices, and prescription drugs currently being taken.
- **For overseeing healthcare providers:** The Plan may disclose information to government agencies that license and inspect medical facilities, such as Hospitals, as required by law.
- **For research:** The Plan may disclose information for a research project that has been approved by a review board. The review board must review the research project and its rules to ensure the privacy of information. Research must be for the purpose of helping the Plan.
- **As required by law:** The Plan will disclose information as required by state or federal law.
- **Disaster relief:** The Plan may use or disclose information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.
- **Public Benefit:** The Plan may use or disclose information as authorized by law for the following purposes deemed to be in the public interest or benefit:
 - Public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or Injury;
 - Reporting adult abuse, neglect, or domestic violence;
 - Health oversight agencies;
 - In response to court and administrative orders and other lawful processes;
 - Law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on State premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
 - Coroners, medical examiners, and funeral directors;
 - Organ procurement organizations;

- Avert a serious threat to health or safety;
- Military and Federal officials for lawful intelligence, counterintelligence, and national security activities;
- Correctional institutions regarding inmates; and
- As authorized by state workers' compensation laws.
- **On Members Authorization:** Members may give written authorization to use medical information or to disclose it to anyone for any purpose. If an authorization is given, Members may revoke it in writing at any time. Revocation will not affect any use or disclosures permitted by authorization while it was in effect. Unless a written authorization is provided, information cannot be used or disclosed for any reason except those described in this notice. The Authorization for the Use and Disclosure of Protected Health Information form is located on <http://benefits.sd.gov>, click Active Employee, scroll over Forms/Documents, and choose Forms/Documents.
- **To Family or Friends:** The Plan may disclose information to a family member, friend, or other person to the extent necessary to help with healthcare or with payment for healthcare. The Plan may use or disclose name, location, and general condition or death to notify, or assist in the notification of a person involved in care.
- Before disclosing information to a person involved with Members healthcare or payment for healthcare, the Plan will provide the Members with an opportunity to object to such uses or disclosures. If not present, or in the event of incapacity or an emergency, the Plan will disclose information based on professional judgment of whether the disclosure would be in best interest of the Members.

Members Rights

Access: Members have the right to obtain copies of information, with limited exceptions. Members may request copies in a format other than photocopies. The Plan will use the format Members requests unless the Plan cannot practicably do so. Members must make a request in writing to obtain access to information. Members may obtain a form to request access by using the contact information listed

at the end of this notice. Members may also request access by sending a letter to the address at the end of this notice. If requesting copies, a cost-based fee will be charged for staff time to locate and copy medical information. If Members want the copies mailed, postage will also be charged.

Disclosure Accounting: Members have the right to receive a list of instances in which the Plan disclosed medical information for purposes other than treatment, payment, healthcare operations, as authorized by Members, and for certain other activities, since April 14, 2003. The Plan will provide the date on which the disclosure was made, the name of the person or entity to whom information was disclosed, a description of the medical information disclosed, the reason for the disclosure, and certain other information. If Members request accounting more than once in a 12-month period, the Plan may charge a reasonable, cost based fee for responding to additional requests. Contact the Plan using the information listed at the end of this notice for a full explanation of the fee structure.

Restriction: Members have the right to request additional restrictions on use or disclosure of information. The Plan is not required to agree to these additional restrictions. Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement on behalf of the State. The State will not be bound unless agreement is in writing.

Confidential Communication: Members have the right to request medical information by alternative means or to alternative locations. Members must make request in writing and the State must accommodate request if it is reasonable, specifies the alternative means or location, and continues to permit collection of contributions and pay claims under the health plan, including issuance of explanations of benefits to the contract holder of the health plan in which Members participate.

Amendment: Members have the right to request State amend medical information. Request must be in writing, and it must explain why the information should be amended. The request may be denied if the State did not create the information to be amended and the originator remains available or for certain other reasons. If request is denied, State will provide a written explanation. Members may respond with a statement of disagreement to be appended to the information you wanted amended.

If State accepts request to amend the information, State will make reasonable efforts to inform others, including Members, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If Members receive this notice on <http://benefits.sd.gov> or by electronic mail (e-mail), Members are entitled to receive this notice in written form. Please use the information listed at the end of this notice to obtain in written form.

For More Information or to Make a Complaint

For more information about State privacy practices, questions, or concerns, please contact the Bureau of Human Resources using the information listed at the end of this notice.

Use information at the end of this notice to express concern about possible violation of privacy rights, to disagree with a decision made about access to medical information, in response to a request to amend or restrict the use or disclosure of medical information or to have State communicate by alternative means or at alternative locations.

Members may also submit a written complaint to the U.S. Department of Health and Human Services. The State will provide the address to file the complaint with the U.S. Department of Health and Human Services upon request.

The State supports the right to the privacy of medical information.

Contact Information:

Mailing Address:

Bureau of Human Resources
500 East Capitol Avenue
Pierre, SD 57501

Telephone:

1.877.573.7347
605.773.3148

Email: BHR.memberbenefits@state.sd.us

Web site: <http://benefits.sd.gov>

CONTACT INFORMATION

CONTACT INFORMATION

BUREAU OF HUMAN RESOURCES

PMB 0141-1
500 East Capitol Avenue
Pierre, SD 57501

605.773.3148

Email:

BHR.memberbenefits@state.sd.us

Web site: <http://benefits.sd.gov>

1.877.573.7347 toll free

Press 1 for DAKOTACARE

Press 2 for Bureau of Human Resources

Press 3 for Latitude

Press 4 for Health Management Partners

Press 5 for Risty Benefits

DAKOTACARE

2600 W 49th Street
Sioux Falls, SD 57105

1.800.831.0785 or
605.334.4000

Email:

state-customer-service@DAKOTACARE.com

Web site:

www.DAKOTACARE.com

DAKOTACARE provides State employees with a system of member doctors and other healthcare providers as well as serves as third party administrator for the Health Plan and Flexible Spending Accounts.

General Health and Flexible Spending Accounts information, including:

- Eligibility questions (for example, if a child is listed as a covered Dependent)
- Questions about claims processing, appeals, coordination of benefits, or third party liabilities
- Covered expenses and benefit level information
- Deductible and out-of-pocket expense information
- Plan limitations and exclusions
- Intensive Case Management information

Health Plan information, including:

- A list of DAKOTACARE medical providers
- A list of participating Chiropractic Associates LTD of South Dakota (CASD) providers
- Additional I.D. cards
- Access to Dependent Care/Day Care Spending Account, Medical Expense Spending Account, and/or Wellness Accounts: www.dakotacareflexonline.com
- Pre-authorization for certain prescriptions to be done at www.dka-pa.com.

DAKOTACARE Access – View EOB Information Online.

DAKOTACARE Access allows secure electronic access to personal DAKOTACARE-related claim information for Health Plan and Flex Spending Accounts:

<http://benefits.sd.gov>, click Active Employee, scroll over Forms/Documents, click Contacts and Resources, and choose DAKOTACARE Access

CVS Caremark

- Questions about the Prescription Network
- Formulary and Maintenance Listing

Customer Service:
1. 866.443.1185

Website: www.caremark.com

**HEALTH MANAGEMENT
PARTNERS (HMP)**

2301 West Russell Street
Sioux Falls, SD 57104

1.866.330.9886 or
605.333.9886

Website: <http://latitude.hmpsd.com>
Pre-auth: www.preauthonline.com

- Health Screenings
- Health Assessments
- Latitude Programs
- Pre-authorization for Hospital confinement or other health services requiring Pre-authorization and medical case management
- Condition Management
- Our Healthy Baby: Register online at www.ourhealthybaby.com or call 1.888.821.2242
- Questions about managed care

**PRIVATE HEALTH CARE
SYSTEMS (PHCS) – Healthy
Directions Network**

1.888.865.7427

Website: www.multiplan.com

- Nationwide Provider Directory
 - Select PHCS Healthy Directions

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 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) **“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.
- (g) **“Benefit Maximum”** - The maximum benefit paid per Member for specific services. See “Master Schedule” and “Benefit Maximum” for listing of services.
- (h) **“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, schizo affective 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.
- (i) **“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.
- (j) **“Chiropractor”** – A chiropractic Physician licensed pursuant to SDCL Chapter 36-5 and who has entered into a service agreement with DAKOTACARE or its designate contractual network.

- (k) **“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.
- (l) **“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.
- (m) **“COBRA”** – The Consolidated Omnibus Reconciliation Act of 1985 and amended thereafter.
- (n) **“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.
- (o) **“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.
- (p) **“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.
- (q) **“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 or their 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); or
 - 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.
- (r) **“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.)
- (s) **“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 \$1,000, your plan won't pay anything until you've met your \$1,000 Deductible for covered health care services subject to the Deductible. The Deductible may not apply to all services.
- (t) **“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) The Employee's Spouse who is not divorced or legally separated from the Employee as recognized by Federal and South Dakota Law;
- 2) 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;
 - b) Not benefit eligible through their employer; and
 - c) Not in military service.

The following individuals are not included in the definition of Dependent except under special COBRA qualifying conditions:

- Ex-Spouse(s) of Employee;
- Children of Employee who are benefit eligible with their employer; and
- Children of Employee who are serving in the military.

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

"Dependent Children" – Children, as defined above, of an employee.

Notwithstanding the above, "Dependent Children" also include 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)).

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

- (x) **“Durable Medical Equipment (DME)”** – Equipment and supplies ordered by a health care provider for everyday or extended use. Coverage for DME may include: oxygen equipment, wheelchairs, crutches, or blood testing strips for diabetics.
- (y) **“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.
- (z) **“Emergency Services”** - Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.
- (aa) **“Enrollment Date”** – The first day of coverage, or if there is a waiting period, the first day of the waiting period.
- (bb) **“ERISA”** – The Employee Retirement Security Income Act of 1974 and amendments thereto.
- (cc) **“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) Reliable Evidence shows that the drug or medicine, device or medical treatment or procedure is the subject of on-going phase I, phase II, phase III, or phase IV clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy, as compared with a standard means of treatment or diagnosis; or
 - 3) Reliable Evidence shows that the consensus of opinion among experts regarding the drug or medicine, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.
Reliable Evidence 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.
 - 4) A drug, medicine, device, medical technology, medical treatment, or procedure which has not been approved by the Plan.
- (dd) **“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.

(ee) **“FMLA”** – The Family Medical Leave Act of 1993 and amendments thereto.

(ff) **“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.

(gg) **“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 31st; 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.

(hh) **“GINA”** – Genetic Information Nondiscrimination Act of 2008 and amendments thereto.

(ii) **“Health Coverage”** - All coverage available under the South Dakota State Employee Health Plan.

- (jj) **“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.
- (kk) **“HIPAA”** – The Health Insurance Portability and Accountability Act of 1996 and amendments thereto.
- (ll) **“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.
- (mm) **“Home Health Care”** – Health care services a person received at home.
- (nn) **“Hospice”** – A facility or program engaged in providing palliative and supportive care of the terminally ill.
- (oo) **“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.

(pp) **“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

(qq) **“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.

(rr) **“Incapacitated Dependent”** – An Incapacitated Dependent must:

- 1) Be incapable of self-support because of intellectual disability as defined in SDCL 10-62-1 or any other mental or physical handicap;
- 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>.

(ss) **“Incurred”** - A charge is deemed “Incurred” on the date the service or supply is provided.

(tt) **“Injury”** - Only bodily Injury sustained accidentally by external means.

- (uu) **“Late Entrants”** - An Eligible Employee 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. A 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 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 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 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.”
- (vv) **“Legal Guardian”** – A person appointed by a court to be responsible for the personal affairs of a minor or protected person.
- (ww) **“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.
- (xx) **“Maintenance Drug”** – Prescribed drugs for chronic, long-term conditions and are taken on a regular basis. Examples of chronic conditions are high blood pressure, high cholesterol, diabetes, and epilepsy. Drugs on a maintenance list are well-established medications with proven history of safety and efficacy. These drugs are typically considered first-line therapies. Medications listed on the Maintenance Drug list are available for three-month supplies.
- (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 or Dependent who is insured under the Plan.
- (ddd) **“Morbid Obesity”** - The point at which there are 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 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”:

- Doctor of Chiropractic (D.C.)
- Doctor of Dental Surgery (D.D.S.)
- Doctor of Medicine (M.D.)
- Doctor of Ophthalmology (M.D.)
- Doctor of Optometry (O.D.)
- Doctor of Osteopathy (D.O.)
- Doctor of Podiatry (D.P.M.)
- Doctor of Psychiatry (M.D.)
- 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) **“Pre-Existing Condition”** - An illness, Injury or condition which existed during the six-months immediately preceding the effective date of coverage if, during that time any professional medical advice, diagnosis, care or treatment was recommended or received. The Pre-existing condition does not apply to Pregnancy or to Dependent children under the age of 19. See when coverage becomes effective under the South Dakota State Employee Health Plan and for information about when a Pre-existing conditions limitation may apply.

(qqq) **“Pre-Existing Waiting Period”** – The twelve-months immediately following the Enrollment Date.

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

(sss) **“Pregnancy”** - The condition of being pregnant and childbirth as well as related medical conditions.

(ttt) **“Primary Care Provider”** - A physician (M.D.-Medical Doctor or D.O. Doctor of Osteopathic Medicine), nurse practitioner, 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.

(uuu) **“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.

- (vvv) **“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 QMCSO 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 QMCSO is no longer in effect.
- (www) **“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).
- (xxx) **“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.
- (yyy) **“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.
- (zzz) **“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.

- (aaaa) **“SDCL”** – South Dakota Codified Laws.

(bbbb) **“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.

(cccc) **“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 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 Dependent as a result of marriage, birth, adoption, or placement for adoption. You may be able to enroll your dependents, provided you request enrollment within 60 days of the event. See “Late Entrants” for situations in which Special Enrollment does not apply.

(dddd) **“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.

(eeee) **“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.

(ffff) **“Spouse”** – An Employee’s husband or wife as a result of marriage that is legally recognized in the state of South Dakota. The Spouse in a common-law marriage is not an Eligible Dependent.

(gggg) **“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.

(hhhh) **“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.

(iiii) **“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.

(jjjj) **“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.

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

MASTER SCHEDULE – \$500 DEDUCTIBLE PLAN

The Plan Year begins on July 1st and ends on June 30th of the following year. All benefits described in this Schedule are subject to the exclusions, limitations, and other provisions of the Plan described in detail with in this document.

ELIGIBILITY REQUIREMENTS FOR FY15 COMPLETED DURING FY14

To be eligible for the lowest deductible plan in FY15, employees and covered spouses must complete a Health Screening, Latitude Program, and Health Assessment during FY14. Eligibility requirements are explained in detail in the Latitude Wellness and Prevention section on page 76

PLAN YEAR DEDUCTIBLE

Members in the \$500 Deductible Plan must satisfy a Plan Year \$500 individual Deductible or \$1,250 family Deductible for care received in-network or from DAKOTACARE providers. Coinsurance applies after Deductible is satisfied.

The Family Deductible applies only to families with three or more covered family members enrolled in the same Plan.

The Plan will begin paying benefits for each individual as soon as the per person Deductible is met. The Family Deductible is satisfied when at least three family members have medical expenses that total the Family Deductible amount. No one family member can meet the entire Family Deductible.

Only charges which apply to the individual Deductible are applied to the Family Deductible. Coinsurance cannot be used to satisfy the Family Deductible. Each covered family member must also satisfy an individual annual Out-of-Pocket Maximum.

HOW THE DEDUCTIBLE IS SATISFIED

A Member can satisfy the Deductible by incurring covered charges in an amount equal to the Deductible within the Plan Year.

The Deductible applies separately to each Member, except:

- (a) If any three or more Members enrolled in the same Plan, satisfy the Family Deductible for the same Plan Year. One Member cannot meet the Family Deductible in the \$500 Deductible Plan.

Only charges which apply to the individual Deductible are applied to the Family Deductible.

The Plan will begin paying benefits for each Member as soon as the individual Deductible or Family Deductible is met.

- (b) If maternity charges are Incurred for a mother and newborn child during the birth of the child, one Deductible and Coinsurance applies to the eligible charges for both individuals — if they are discharged from the Hospital at the same time.

Non-covered charges do not apply to the Deductible. This includes charges above the Usual, Customary,

and Reasonable (UCR) charges or the Plan Maximum Allowable Charges (MAC), and cost variance when covered services are provided at facilities not under contract to receive the South Dakota State Employee Health Plan set payment for those services.

If a Member elects COBRA and changes from the \$500 Deductible Plan to the \$1,000 Deductible Plan, eligible Copayments and Coinsurance applied during the Plan Year while under the \$500 Deductible Plan will apply to the annual Deductible.

COMBINED FAMILY DEDUCTIBLE

Under the \$500 Deductible Plan families with both spouses employed by the State, may combine their plans to meet the family Deductible.

Criteria:

- 1) Married
- 2) Both spouses employed by State of South Dakota and/or Board of Regents
- 3) Both spouses elected the same Plan.
- 4) Coverage level:
 - a) One spouse is covered as single
 - b) One spouse is covered with Dependent(s)
- 5) Request must be submitted during annual enrollment asking BHR to combine Deductibles.

Complete the following to request combined family Deductible:

- 1) Send an email to BHR.memberbenefits@state.sd.us
- 2) Include:
 - a) Employee name, DAKOTACARE #, and plan (\$500 or \$1,000)
 - b) Spouse name, DAKOTACARE #, and plan (\$500 or \$1,000)
- 3) Indicate which Employee covers Dependent(s) on the Health Plan.
- 4) Include a statement asking BHR to combine Deductibles.

MASTER SCHEDULE – \$500 DEDUCTIBLE PLAN

COINSURANCE AND COPAYMENTS UNDER THE \$500 DEDUCTIBLE PLAN

Once the Deductible is satisfied, the Member pays a percentage of the allowable costs (the “Coinsurance” or “Benefit Percentage”). A member pays an Emergency Room Copayment each time services are rendered. The ER Copayment is not applied toward the Deductible or Out-of-Pocket Maximum. ER Copayment is waived if admitted as Inpatient.

The type of service received and the provider used determines the benefits covered by the Plan and whether Copayments or Coinsurance are payable. If care is managed by the Physician and coordinated through the DAKOTACARE network of providers, Coinsurance is 25%, when applicable. If care is provided out-of-network, the Member must meet a \$1,000 Deductible and Coinsurance increases to 35% for most covered expenses. The Member also pays any charges above UCR or MAC.

NOTE: If a Plan Member is Hospitalized over two Plan Years (for example from June 26 to July 3), a Deductible and Coinsurance carryover policy will apply. The Plan Member will not have to pay an additional Deductible for a period of confinement continuing into the new Plan Year. Charges for the Hospitalization will apply to the first year’s Out-of-Pocket Maximum. Expenses Incurred after the Hospitalization will apply to the new Plan Year limit.

Eligible Members	All benefit-eligible Members.	Member Responsibility**
<hr/>		
<i>Deductible</i>		
<i>In-Network</i>		\$500 (per individual) \$1,250 (per family of three or more)
<i>Out-of-Network</i>		\$1,000 (per individual) \$2,500 (per family of three or more)
<hr/>		
<i>Coverage In-Network</i>		
	(a) Per Emergency Room Visit	\$250 per visit, Deductible, then Coinsurance
	(b) Prescription Drugs	\$50 Deductible, then applicable Copayment.

* *These services must be pre-authorized and be performed at a preferred contracted facility.*

** *See Covered Charges, for additional information.*

Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR or MAC are not applied to the medical Out-of-Pocket Maximum

MASTER SCHEDULE – \$500 DEDUCTIBLE PLAN

Eligible Members	All benefit-eligible Members.	Member Responsibility**
Room and Board Coverage	(a) Private Room*	When Medically Necessary, the daily charge made by the facility for: <ul style="list-style-type: none"> • semi-private accommodations; • private accommodations
	(b) Other Accommodations*	Full Semi-Private Room Charge
Benefit Maximums (lifetime maximum per person)	(a) Organ Procurement for Transplant*	\$50,000
	(b) Diagnosis and Treatment:	
	1) Temporomandibular Joint Syndrome (TMJ)*	\$5,000
	2) Gastric Bypass Surgery and Similar Types of Surgery*	1 per person
	3) Ossastron Lithotripsy (Shock Wave Treatment for Chronic Plantar Fasciitis)	\$5,000
(c) Infertility Diagnosis and Medically Necessary Treatment	\$3,000 for all medical services combined <i>(Excludes infertility drugs)</i>	
(d) Smoking Cessation Aids that Require a Prescription	180 days	

* *These services must be pre-authorized and be performed at a preferred contracted facility.*

** *See Covered Charges, for additional information.*

Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR or MAC are not applied to the medical Out-of-Pocket Maximum.

MASTER SCHEDULE – \$500 DEDUCTIBLE PLAN

BENEFIT PERCENTAGES (COINSURANCE) UNDER THE \$500 DEDUCTIBLE PLAN

The Coinsurance payment is the percentage of covered charges paid by the Member after the Deductible is satisfied. Coinsurance percentages are determined by the provider used.

Members should select a DAKOTACARE Primary Care Provider to manage and coordinate care for themselves and Dependents. Physicians may include: family practitioners, general practitioners, general internists, general pediatricians or OB GYN.

If members use a DAKOTACARE Network provider, the member is responsible for the Deductible then 25% Coinsurance. If members use a non-DAKOTACARE Network provider, the member is responsible for the Deductible then 35% Coinsurance.

Primary care providers provide basic or routine services, Preventive Care, and will refer Patients to participating DAKOTACARE specialists or Hospitals as necessary. In some cases, a DAKOTACARE specialist may require a referral from your Physician before an appointment is scheduled.

If chiropractors participating in the Chiropractic Associates LTD of South Dakota (CASD) Chiropractic Network are used, the Member is responsible for Deductible, then 25% Coinsurance.

If non-CASD chiropractors are used, the Member is responsible for Deductible, then 35% Coinsurance and is responsible for charges over UCR or MAC.

If South Dakota Department of Health or the South Dakota Human Services Center in Yankton is used, the Member is responsible for Deductible, then 25% Coinsurance.

When other healthcare providers or facilities which the State has negotiated services are used, the Member is responsible for Deductible, then 25% Coinsurance.

MEDICAL OUT-OF-POCKET MAXIMUM UNDER THE \$500 DEDUCTIBLE PLAN

The medical Out-of-Pocket Maximum is \$2,500 per person for covered medical expenses each Plan Year. The maximum consists of any Deductible and Coinsurance payments, as well as payments for Outpatient Surgeries at contracted facilities. Emergency Room Copayments do not count towards the medical Out-of-Pocket Maximum.

If a Tier 1 service is done at a Tier 1 facility the individual Out-of-Pocket Maximum remains at \$2,500 for medical costs. If a service available at a Tier 1 facility is done at a Non-Tier 1 facility but still In-Network, an individual member will be responsible for \$5,000 medical Out-of-Pocket Maximum.

When a Member receives services from DAKOTACARE and non-DAKOTACARE providers, eligible charges from both will apply to the Out-of-Pocket limits. The maximum paid for eligible combined out-of-pocket expenses is \$5,000 per person.

MASTER SCHEDULE – \$500 DEDUCTIBLE PLAN

In-Network	
<ul style="list-style-type: none"> • Deductible \$500 • Copayment • Coinsurance 75/25 • Maximum Out-of-Pocket \$2,500 • Tier 1 Maximum Out-of-Pocket \$2,500 • Non-Tier 1 Maximum Out-Of-Pocket \$5,000 	<p>Applies to covered charges:</p> <ul style="list-style-type: none"> • DAKOTACARE Provider, In State • Out-of-state DAKOTACARE Provider • Non-DAKOTACARE Provider * • Out of State PHCS Provider when Member resides out of State * • Non-PHCS Provider when Member resides out of State * <p>Charges covered to the Maximum Allowable Charges (MAC) and/or the Usual, Customary, and Reasonable (UCR).</p>
Out-of-Network	
<ul style="list-style-type: none"> • Deductible \$1,000 • Coinsurance 65/35 • Maximum Out-of-Pocket \$5,000 	<p>Applies to covered charges :</p> <ul style="list-style-type: none"> • Non-DAKOTACARE Provider • Out-of-state Provider who is Out of Network • Non-preferred out-of-state provider when services are available in state <p>Charges covered to the Maximum Allowable Charges (MAC) and/or the Usual, Customary, and Reasonable (UCR).</p>

* Some services require pre-authorization by HMP. Services must be approved by HMP and In Network to be covered at the Maximum Benefit Level.

Note: Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR or MAC do not apply to the medical out-of-pocket. Call DAKOTACARE at 877.573.7347, option 1 to inquire about your benefit coverage.

MASTER SCHEDULE – \$500 DEDUCTIBLE PLAN

Medical Out-of-Pocket Maximum

In-Network \$2,500 per person
Tier 1 \$2,500 per person
Non Tier 1 \$5,000 per person
Out-of-Network \$5,000 per person

If a Member reaches the medical Out-of-Pocket Maximum, the Plan pays 100% of eligible charges up to the Plan Maximum Allowable Charges (MAC) or Usual, Customary, and Reasonable charges (UCR) for most eligible expenses for the rest of the Plan Year.

The Medical Out-of-Pocket Maximum **includes**:

- Medical Deductible
- Coinsurance

The Medical Out-of-Pocket Maximum **does not include**:

- \$250 Emergency Room Copayment
 - Pharmacy (see Pharmacy)
 - Expenses not covered by the Plan (see Exclusions)
 - Penalties for not receiving Pre-authorization from HMP when required.
 - Any charges above UCR or MAC.
-

Pharmacy Out-of-Pocket Maximum

The per Member Out-of-Pocket for eligible prescription drug expenses each Plan Year is \$1,000 per Member or \$2,500 total for a family of three or more.

The pharmacy Out-of-Pocket Maximum includes a \$50 Deductible and pharmacy Copayments. If the actual cost of the drug is less than the Copayment, that amount will also apply to the Plan Year maximums.

The pharmacy Out-of-Pocket does not include:

- The difference in cost between brand and generic drugs when a generic is available,
 - Excess amounts paid at nonparticipating pharmacies, or
 - Charges that are not covered by the Plan or cost of prescription for not pre-authorizing when required.
-

MASTER SCHEDULE – \$1,000 DEDUCTIBLE PLAN

The Plan Year begins on July 1st and ends on June 30th of the following year. All benefits described in this Schedule are subject to the exclusions, limitations, and other provisions of the Plan described in detail with in this document.

PLAN YEAR DEDUCTIBLE

Members in the \$1,000 Deductible Plan must satisfy a \$1,000 individual Deductible or a \$2,500 family Deductible for care received in-network or from DAKOTACARE providers. Coinsurance applies after the Deductible is satisfied.

The Family Deductible applies only to families with three or more covered family members enrolled in the same Plan.

The Plan will begin paying benefits for each individual as soon as the per person Deductible is met. The Family Deductible is satisfied when at least three family members have medical expenses that total the Family Deductible amount. No one family member can meet the entire Family Deductible.

Only charges which apply to the individual Deductible are applied to the Family Deductible. Coinsurance cannot be used to satisfy the Family Deductible. Each covered family member must also satisfy an individual annual Out-of-Pocket Maximum.

HOW THE DEDUCTIBLE IS SATISFIED

A Member can satisfy the Deductible by incurring covered charges in an amount equal to the Deductible within the Plan Year.

The Deductible applies separately to each Member, except:

- (a) If any three or more Members enrolled in the same Plan, satisfy the Family Deductible for the same Plan Year. One Member cannot meet the Family Deductible in the \$1,000 Deductible Plan.

Only charges which apply to the individual Deductible are applied to the Family Deductible.

The Plan will begin paying benefits for each Member as soon as the individual Deductible or Family Deductible is met.

- (b) If maternity charges are Incurred for a mother and newborn child during the birth of the child, one Deductible and Coinsurance applies to the eligible charges for both individuals — if they are discharged from the Hospital at the same time.

Non-covered charges do not apply to the Deductible. This includes charges above the Usual, Customary, and Reasonable (UCR) charges or the Plan Maximum Allowable Charges (MAC), and cost variance when covered services are provided at facilities not under contract to receive the South Dakota State Employee Health Plan set payment for those services.

If a Member elects COBRA and changes from the \$500 Deductible Plan to the \$1,000 Deductible Plan, eligible Copayments and Coinsurance applied during the Plan Year while under the \$500 Deductible Plan will apply to the annual Deductible.

COMBINED FAMILY DEDUCTIBLE

Under the \$500 Deductible Plan and the \$1,000 Deductible Plan, families with both spouses employed by the State, may combine their plans to meet the family Deductible.

Criteria:

- 1) Married
- 2) Both spouses employed by State of South Dakota and/or Board of Regents
- 3) Both spouses elected the same Plan: \$500 Deductible Plan or \$1,000 Deductible. With IRS rules, there is no opportunity for combined Deductibles under the \$1,800 Deductible Plan.
- 4) Coverage level:
 - a) One spouse is covered as single
 - b) One spouse is covered with Dependent(s)
- 5) Request must be submitted during annual enrollment asking BHR to combine Deductibles.

Complete the following to request combined family Deductible:

- 1) Send an email to BHR.memberbenefits@state.sd.us
- 2) Include:
 - a) Employee name, DAKOTACARE #, and plan (\$500 or \$1,000)
 - b) Spouse name, DAKOTACARE #, and plan (\$500 or \$1,000)
- 3) Indicate which Employee covers Dependent(s) on the Health Plan.
- 4) Include a statement asking BHR to combine Deductibles.

MASTER SCHEDULE – \$1,000 DEDUCTIBLE PLAN

COINSURANCE & COPAYMENTS UNDER THE \$1,000 DEDUCTIBLE PLAN

Once the Deductible is satisfied, the Member pays a percentage of the allowable costs (the “Coinsurance” or “Benefit Percentage”). A member pays an Emergency Room Copayment each time services are rendered. The ER copayment is not applied toward the Deductible or Out-of-Pocket Maximum. ER Copayment is waived if admitted as Inpatient.

The type of service received and the provider used determines the benefits covered by the Plan and whether Copayments or Coinsurance are payable. If care is managed by the Physician and coordinated through the DAKOTACARE network of providers, Coinsurance is 25%, when applicable. If care is provided out-of-network, the Member must meet a \$1,000 Deductible and Coinsurance increases to 35% for most covered expenses. The Plan pays 65%. The Member also pays any charges above Usual, Customary, and Reasonable (UCR) or Maximum Allowable Charges (MAC).

NOTE: If a Plan Member is Hospitalized over, two Plan Years (for example from June 26 to July 3), a Deductible and Coinsurance carryover policy will apply. The Plan Member will not have to pay an additional Deductible for a period of confinement continuing into the new Plan Year. Charges for the Hospitalization will apply to the first year’s Out-of-Pocket Maximum. Expenses Incurred after the Hospitalization will apply to the new Plan Year limit.

Eligible Members	All benefit-eligible Members.	Member Responsibility**
<i>Deductible</i>		
<i>In-Network</i>		\$1,000 (per individual)
<i>and</i>		\$2,500 (per family of three
<i>Out-of-Network</i>		or more)
<i>Coverage In-Network</i>	(a)	Per Emergency Room Visit
		\$250 per visit, Deductible, then Coinsurance
	(b)	Prescription Drugs
		\$50 Deductible, then applicable Copayment.

* *These services must be pre-authorized and performed at a preferred contracted facility.*

** *See Covered Charges, for additional information.*

Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR or MAC not applied to the medical Out-of-Pocket Maximum

MASTER SCHEDULE – \$1,000 DEDUCTIBLE PLAN

Eligible Members	All benefit-eligible Members.	Member Responsibility**
Room and Board Coverage	(a) Private Room*	When Medically Necessary, the daily charge made by the facility for: <ul style="list-style-type: none"> • semi-private accommodations; • private accommodations
	(b) Other Accommodations*	Full Semi-Private Room Charge
Benefit Maximums <i>(lifetime maximum per person)</i>	(a) Organ Procurement for Transplant*	\$50,000
	(b) Diagnosis and Treatment:	
	4) Temporomandibular Joint Syndrome (TMJ)*	\$5,000
	5) Gastric Bypass Surgery and Similar Types of Surgery*	1 per person
	6) Ossonon Lithotripsy (Shock Wave Treatment for Chronic Plantar Fasciitis)	\$5,000
(c) Infertility Diagnosis and Medically Necessary Treatment	\$3,000 for all medical services combined <i>(Excludes infertility drugs)</i>	
(d) Smoking Cessation Aids that Require a Prescription	180 days	

* *These services must be pre-authorized and performed at a preferred contracted facility.*

** *See Covered Charges, for additional information.*

Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR or MAC not applied to the medical Out-of-Pocket Maximum

MASTER SCHEDULE – \$1,000 DEDUCTIBLE PLAN

BENEFIT PERCENTAGES (COINSURANCE) UNDER THE \$1,000 DEDUCTIBLE PLAN

The Coinsurance payment is the percentage of covered charges paid by the Member after the Deductible and/or Copayment is satisfied. Coinsurance percentages are determined by the provider used.

Members should select a DAKOTACARE Primary Care Provider to manage and coordinate care for themselves and Dependents. Physicians may include: family practitioners, general practitioners, general internists, general pediatricians or OB GYN.

If members use a DAKOTACARE Network provider, the member is responsible for the Deductible then, 25% Coinsurance. If members use a non-DAKOTACARE Network provider, the member is responsible for the Deductible, then 35% Coinsurance.

Primary care providers provide basic or routine services, Preventive Care, and will refer Patients to participating DAKOTACARE specialists or Hospitals as necessary. In some cases, a DAKOTACARE specialist may require a referral from your Physician before an appointment is scheduled.

If chiropractors participating in the Chiropractic Associates LTD of South Dakota (CASD) Chiropractic Network are used, the Member is responsible for Deductible, then 25% Coinsurance.

If non-CASD chiropractors are used, the Member is responsible for Deductible, then 35% Coinsurance and is responsible for charges over UCR or MAC.

If South Dakota Department of Health or the South Dakota Human Services Center in Yankton is used, the Member is responsible for Deductible, then 25% Coinsurance.

When other healthcare providers or facilities which the State has negotiated services are used, the Member is responsible for the Deductible, then 25% Coinsurance.

MEDICAL OUT-OF-POCKET MAXIMUM UNDER THE \$1,000 DEDUCTIBLE PLAN

The medical Out-of-Pocket Maximum is \$3,500 per person for covered medical expenses each Plan Year. The maximum consists of any Deductible and Coinsurance payments, as well as payments for Outpatient Surgeries at preferred contracted facilities. Emergency Room Copayments do not count towards the medical Out-of-Pocket Maximum.

If a Tier 1 service is done at a Tier 1 facility an individual Out of Pocket Maximum remains at \$3,500 for medical costs. If a service available at a Tier 1 facility is done at a Non-Tier 1 facility but still In-Network, an individual member will be responsible for \$5,000 medical Out-of-Pocket Maximum.

When a Member receives services from DAKOTACARE and non-DAKOTACARE providers, eligible charges from both will apply to the Out-of-Pocket limits. The maximum paid for eligible combined out-of-pocket expenses is \$5,000 per person.

MASTER SCHEDULE – \$1,000 DEDUCTIBLE PLAN

In-Network	
<ul style="list-style-type: none"> • Deductible \$1,000 • Coinsurance 75/25 • Maximum Out-of-Pocket \$3,500 • Tier 1 Maximum Out-of-Pocket \$3,500 • Non-Tier 1 Maximum Out-of-Pocket \$5,000 	<p>Applies to covered charges:</p> <ul style="list-style-type: none"> • DAKOTACARE Provider, In State • Out-of-state DAKOTACARE Provider • Non-DAKOTACARE Provider * • Out of State PHCS Provider when Member resides out of State * • Non-PHCS Provider when Member resides out of State * <p>Charges covered to the Maximum Allowable Charges (MAC) and/or the Usual, Customary, and Reasonable (UCR).</p>
Out-of-Network	
<ul style="list-style-type: none"> • Deductible \$1,000 • Coinsurance 65/35 • Maximum Out-of-Pocket \$5,000 	<p>Applies to covered charges :</p> <ul style="list-style-type: none"> • Non-DAKOTACARE Provider • Out-of-state Provider who is Out of Network • Non-preferred out-of-state provider when services are available in state <p>Charges covered to the Maximum Allowable Charges (MAC) and/or the Usual, Customary, and Reasonable (UCR).</p>

* Some services require pre-authorization by HMP. Services must be approved by HMP and In Network to be covered at the Maximum Benefit Level.

Note: Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR or MAC do not apply to the medical out-of-pocket. Call DAKOTACARE at 877.573.7347, option 1 to inquire about your benefit coverage.

MASTER SCHEDULE – \$1,000 DEDUCTIBLE PLAN

Medical Out-of-Pocket Maximum

In-Network \$3,500 per person
Tier 1 \$3,500 per person
Non-Tier 1 \$5,000 per person
Out-of-Network \$5,000 per person

If a Member reaches the medical Out-of-Pocket Maximum, the Plan pays 100% of eligible charges up to the Plan Maximum Allowable Charges (MAC) or Usual, Customary, and Reasonable charges (UCR) for most eligible expenses for the rest of the Plan Year.

The Medical Out-of-Pocket Maximum **includes**:

- Medical Deductible
- Coinsurance

The Medical Out-of-Pocket Maximum **does not include**:

- \$250 Emergency Room Copayment
 - Pharmacy (see Pharmacy)
 - Expenses not covered by the Plan (see Exclusions)
 - Penalties for not receiving Pre-authorization from HMP when required.
 - Any charges above UCR or MAC.
-

Pharmacy Out-of-Pocket Maximum

The per Member Out-of-Pocket for eligible prescription drug expenses each Plan Year is \$1,000 per Member or \$2,500 total for a family of three or more.

The pharmacy Out-of-Pocket Maximum includes a \$50 Deductible and pharmacy Copayments. If the actual cost of the drug is less than the Copayment, that amount will also apply to the Plan Year maximums.

The pharmacy Out-of-Pocket does not include:

- The difference in cost between brand and generic drugs when a generic is available,
 - Excess amounts paid at nonparticipating pharmacies, or
 - Charges that are not covered by the Plan or cost of prescription for not pre-authorizing when required.
-

MASTER SCHEDULE – \$1,800 DEDUCTIBLE PLAN

The Plan Year begins on July 1st and ends on June 30th of the following year. All benefits described in this Schedule are subject to the exclusions, limitations, and other provisions of the Plan described in detail with in this document.

PLAN YEAR DEDUCTIBLE

Members in the \$1,800 Deductible Plan must satisfy a \$1,800 Single Deductible or a \$3,600 Family Deductible each Plan Year. All eligible charges, including prescription drugs, apply to Deductible. If member has family coverage (two or more covered members) the Family Deductible must be met before payment of benefits will begin.

The Family Deductible applies to families with two or more covered family members enrolled in the same Plan.

The Plan will begin paying benefits as soon as the Deductible is met. The Family Deductible is satisfied when at least one or a combination of family member has medical and pharmacy expenses that total the Family Deductible amount. One family member can meet the entire Family Deductible.

Only charges which apply to the Single Deductible are applied to the Family Deductible. Coinsurance cannot be used to satisfy the Family Deductible. One family member could satisfy the Family annual Out-of-Pocket Maximum.

HOW THE DEDUCTIBLE IS SATISFIED

A Member can satisfy the Deductible by incurring covered charges in an amount equal to the Deductible within the Plan Year. Single Coverage - \$1,800 Deductible, Family Coverage - \$3,600

The Deductible applies separately to each Member, except:

- (a) One member enrolled in the \$1,800 Deductible Plan can satisfy the Family Deductible for the Plan Year. One Member can meet the Family Deductible of \$3,600 when enrolled in the \$1,800 Deductible Plan.

Only charges which apply to the Single Deductible are applied to the Family Deductible.

The Plan will begin paying benefits for each Member as soon as the Single Deductible (\$1,800) or Family Deductible (\$3,600) is met.

- (b) If maternity charges are Incurred for a mother and newborn child during the birth of the child, one Deductible applies to the eligible charges for both individuals — if they are discharged from the Hospital at the same time.

Non-covered charges do not apply to the Deductible. This includes charges above the Usual, Customary, and Reasonable (UCR) charges or the Plan Maximum Allowable Charges (MAC), and cost variance when covered services are provided at facilities not under contract to receive the South Dakota State Employee Health Plan set payment for those services.

COMBINED FAMILY DEDUCTIBLE

With IRS rules, there is no opportunity for combined Deductibles under the \$1,800 Deductible Plan.

HEALTH SAVINGS ACCOUNT (HSA)

A Health Savings Account (HSA) is an account which enables the member to pay for covered medical expenses with pre-tax dollars.

Members enrolled in the \$1,800 Deductible Plan are eligible to establish a Health Savings Account.

Medical expenses, which are eligible for reimbursement, are described under the Internal Revenue Code, Section 152. See IRS Publication 502 for a complete list, or consult with a qualified tax consultant. www.irs.gov/pub/irs-pdf/p502.pdf.

Contributions the member and the State make grow with interest over time and can be taken with the member when the member retires or terminates employment with the State. Contributions, earnings, and withdrawals, used for qualifying medical care are all tax-free.

If a member establishes an HSA, the state will contribute \$300 to the account. The member can also make tax-free contributions to the HSA, up to limits established by the IRS.

Catch-up contributions in the amount of \$1,000 are allowed for individuals age 55 or older. Unused Health Savings Account contributions may be carried over from one Plan Year to the next.

	Employer		Employee	HSA Contribution 2013
Employee Only	\$300	+	\$2,950	\$3,250
Employee and Spouse	\$300	+	\$6,150	\$6,450
Employee and child(ren)	\$300	+	\$6,150	\$6,450
Family	\$300	+	\$6,150	\$6,450

MASTER SCHEDULE – \$1,800 DEDUCTIBLE PLAN

COINSURANCE UNDER THE \$1,800 DEDUCTIBLE PLAN

With IRS rules, there are no copayments under the \$1,800 Deductible Plan.

NOTE: If a Plan Member is Hospitalized over two Plan Years (for example from June 26 to July 3), a Deductible and Coinsurance carryover policy will apply. The Plan Member will not have to pay an additional Deductible for a period of confinement continuing into the new Plan Year. Charges for the Hospitalization will apply to the first year's Out-of-Pocket Maximum. Expenses Incurred after the Hospitalization will apply to the new Plan Year limit.

Eligible Members	All benefit-eligible Members.	Member Responsibility**
<i>Deductible In-Network and Out-of-Network</i>		\$1,800 Single Coverage \$3,600 Family Deductible must be met before benefits are paid for any family member.
<i>Coverage In-Network</i>	(a) Per Emergency Room Visit *	Applies to Deductible Coverage
	(b) Certain Eligible Preventive Care	(See Latitude Wellness and Prevention, page 89)
	(c) Prescription Drugs	Applies to Deductible then Coinsurance

* *These services must be pre-authorized and performed at a preferred contracted facility.*

** *See Covered Charges, for additional information.*

Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR or MAC not applied to the medical Out-of-Pocket Maximum

MASTER SCHEDULE – \$1,800 DEDUCTIBLE PLAN

Eligible Members	All benefit-eligible Members.	Member Responsibility**
Room and Board Coverage	(a) Private Room*	When Medically Necessary, the daily charge made by the facility for: <ul style="list-style-type: none"> • semi-private accommodations; • private accommodations
	(b) Other Accommodations*	Full Semi-Private Room Charge
Benefit Maximums <i>(lifetime maximum per person)</i>	(a) Organ Procurement for Transplant*	\$50,000
	(b) Diagnosis and Treatment:	
	7) Temporomandibular Joint Syndrome (TMJ)*	\$5,000
	8) Gastric Bypass Surgery and Similar Types of Surgery*	1 per person
	9) Ossastron Lithotripsy (Shock Wave Treatment for Chronic Plantar Fasciitis)	\$5,000
(c) Infertility Diagnosis and Medically Necessary Treatment	\$3,000 for all medical services combined <i>(Excludes infertility drugs)</i>	
(d) Smoking Cessation Aids that Require a Prescription	180 days	

* *These services must be pre-authorized and performed at a preferred contracted facility.*

** *See Covered Charges, for additional information.*

Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR or MAC not applied to the medical Out-of-Pocket Maximum

MASTER SCHEDULE – \$1,800 DEDUCTIBLE PLAN

BENEFIT PERCENTAGES (COINSURANCE) UNDER THE \$1,800 DEDUCTIBLE PLAN

The Coinsurance payment is the percentage of covered charges paid by the Member after the Deductible is satisfied. Coinsurance percentages are determined by the provider used.

Members should select a DAKOTACARE Primary Care Provider to manage and coordinate care for themselves and Dependents. Physicians may include: family practitioners, general practitioners, general internists, general pediatricians or OB GYN.

If members use a DAKOTACARE Network provider, the member is responsible for the Deductible, then 25% Coinsurance. If members use a non-DAKOTACARE Network provider, the member is responsible for the Deductible, then 35% Coinsurance.

Primary care providers provide basic or routine services, Preventive Care, and will refer Patients to participating DAKOTACARE specialists or Hospitals as necessary. In some cases, a DAKOTACARE specialist may require a referral from your Physician before an appointment is scheduled.

If chiropractors participating in the Chiropractic Associates LTD of South Dakota (CASD) Chiropractic Network are used, the Member is responsible for Deductible, then 25% Coinsurance.

If non-CASD chiropractors are used, the Member is responsible for Deductible, then 35% Coinsurance and is responsible for charges over UCR or MAC.

If South Dakota Department of Health or the South Dakota Human Services Center in Yankton are used, the Member is responsible for Deductible, then 25% Coinsurance.

When other healthcare providers or facilities which the State has negotiated services are used, the Member is responsible for Deductible, then pays 25% Coinsurance

MEDICAL AND PHARMACY OUT-OF-POCKET MAXIMUM UNDER THE \$1,800 DEDUCTIBLE PLAN

The medical and pharmacy Out-of-Pocket Maximum is \$3,600 for Single coverage and \$7,200 for Family coverage medical expenses each Plan Year. The maximum consists of any Deductible and Coinsurance payments.

If a Tier 1 service is done at a Tier 1 facility an individual Out-of-Pocket Maximum remains at \$3,600 for medical and pharmacy costs. If a Tier 1 service available at a Tier 1 facility is done at a Non-Tier 1 facility but still in-network, an individual member will be responsible for \$5,400 medical Out-of-Pocket Maximum for medical and pharmacy and \$10,800 for family coverage.

When a Member receives services from DAKOTACARE and non-DAKOTACARE providers, eligible charges from both will apply to the Out-of-Pocket limits. The maximum paid for eligible combined out-of-pocket expenses is \$5,400 for Single coverage and \$10,800 for Family coverage.

\$1,800 Deductible Plan Medical and Pharmacy Out-of-Pocket Maximum

Network Provider	Out-of-Network Provider
<ul style="list-style-type: none">• \$3,600 Single coverage• \$7,200 Family coverage	<ul style="list-style-type: none">• \$5,400 Single coverage• \$10,800 Family coverage

MASTER SCHEDULE – \$1,800 DEDUCTIBLE PLAN

In-Network	
<ul style="list-style-type: none"> • Deductible Single Coverage \$1,800 Family Coverage \$3,600 • Coinsurance 75/25 • Maximum Out-of-Pocket Single Coverage \$3,600 Family Coverage \$7,200 Tier 1 Single \$3,600 Tier 1 Family \$7,200 Non-Tier 1 Single \$5,400 Non-Tier 1 Family \$10,800 	<p>Applies to covered charges:</p> <ul style="list-style-type: none"> • DAKOTACARE Provider, In State • Out-of-state DAKOTACARE Provider • Non-DAKOTACARE Provider * • Out of State PHCS Provider when Member resides out of State * • Non-PHCS Provider when Member resides out of State * <p>Charges covered to the Maximum Allowable Charges (MAC) and/or the Usual, Customary, and Reasonable (UCR).</p>
Out-of-Network	
<ul style="list-style-type: none"> • Deductible Single Coverage \$1,800 Family Coverage \$3,600 • Coinsurance 65/35 • Maximum Out-of-Pocket Single Coverage \$5,400 Family Coverage \$10,800 	<p>Applies to covered charges :</p> <ul style="list-style-type: none"> • Non-DAKOTACARE Provider • Out-of-state Provider who is Out of Network • Non-preferred out-of-state provider when services are available in state <p>Charges covered to the Maximum Allowable Charges (MAC) and/or the Usual, Customary, and Reasonable (UCR).</p>

* Some services require pre-authorization by HMP. Services must be approved by HMP and In Network to be covered at the Maximum Benefit Level.

Note: Depending on services received and facility used, Member may incur additional expenses. Charges above the UCR and MAC do not apply to the medical out-of-pocket. Call DAKOTACARE at 877.573.7347, option 1 to inquire about your benefit coverage.

MASTER SCHEDULE – \$1,800 DEDUCTIBLE PLAN

<i>Medical and Pharmacy Out-of-Pocket Maximum</i>	In-Network \$3,600 per person \$7,200 per family
	Tier 1 \$3,600 per person \$7,200 per family
	Non-Tier 1 \$5,400 per person \$10,800 per family

If a Member reaches the medical and pharmacy Out-of-Pocket Maximum, the Plan pays 100% of eligible charges up to the Plan Maximum Allowable Charges (MAC) or Usual, Customary, and Reasonable charges (UCR) for most eligible expenses for the rest of the Plan Year.

Out-of-Network \$5,400 per person
\$10,800 per family

The Medical Out-of-Pocket Maximum **includes**:

- Medical Deductible
- Coinsurance
- Pharmacy

If a Member reaches the Medical and Pharmacy Out-of-Pocket Maximum, the Plan pays 100% of eligible charges up to the Plan Maximum Allowable Charges (MAC) or Usual, Customary, and Reasonable charges (UCR) for most eligible expenses for the rest of the Plan Year.

The Medical Out-of-Pocket Maximum **does not include** the following:

- Expenses not covered by the Plan.
 - Penalties for not receiving Pre-authorization from HMP when required.
 - Any charges above UCR or MAC
-

HEALTH PLAN COMPARISON CHART

South Dakota State Employee Health Plan Coverage Details for FY14						
Plan Details	\$500 Deductible Plan		\$1,000 Deductible Plan		\$1,800 Deductible Plan with HSA	
	Network Provider	Out-of-Network Provider ¹	Network Provider	Out-of-Network Provider ¹	Network Provider	Out-of-Network Provider ¹
Eligible Preventive Services	Covered	Subject to UCR	Covered	Subject to UCR	Covered	Subject to UCR
Plan Year Deductible	<ul style="list-style-type: none"> \$500 per person \$1,250 for family of three or more 	<ul style="list-style-type: none"> \$1,000 per person \$2,500 for family of three or more 	<ul style="list-style-type: none"> \$1,000 per person \$2,500 for family of three or more 		<ul style="list-style-type: none"> \$1,800 for single coverage \$3,600 for family coverage <p>If you have family coverage, the full family deductible must be met before benefits are paid for any family member.</p>	
Copayment	• Emergency Room: \$250 ²		• Emergency Room: \$250 ²		N/A	
Coinsurance	<ul style="list-style-type: none"> Plan pays 75% after deductible You pay 25% 	<ul style="list-style-type: none"> Plan pays 65% after deductible You pay 35% 	<ul style="list-style-type: none"> Plan pays 75% after deductible You pay 25% 	<ul style="list-style-type: none"> Plan pays 65% after deductible You pay 35% 	<ul style="list-style-type: none"> Plan pays 75% after deductible You pay 25% 	<ul style="list-style-type: none"> Plan pays 65% after deductible You pay 35%
Plan Year Out-of-Pocket Maximum ²	\$2,500 (per person)	\$5,000 (per person)	\$3,500 (per person)	\$5,000 (per person)	<ul style="list-style-type: none"> \$3,600 single coverage ³ \$7,200 per family ³ 	<ul style="list-style-type: none"> \$5,400 single coverage ³ \$10,800 per family ³
State Health Savings Account contribution	N/A		N/A		\$300 for employee only with proof of HSA	
Prescription Drugs						
Deductible (per person)	\$50	\$50	\$50	\$50	Included in Plan Deductible ³	
Out-of-Pocket Maximum	<ul style="list-style-type: none"> \$1,000 per person \$2,500 for family of three or more 				Included in Plan Out-of-Pocket Maximum ³	

¹ Out-of-network provider means:

- A DAKOTACARE network provider did not provide care; or
- You did not receive approval from Health Management Partners, for a referral to an out-of-network provider; or
- You failed to obtain preauthorization when necessary.

² The following charges do NOT apply to the out-of-pocket maximum:

- The ER copayment;
- Expenses not covered by the Plan;
- Penalties for not receiving preauthorization from Health Management Partners when required;
- Any charges above usual, customary, and reasonable (UCR) or the allowed Plan maximums.

³ When insured under the \$1,800 Deductible Plan, all costs of prescription drugs apply to the deductible and then coinsurance. There are no prescription copayments.

ELIGIBILITY AND SELECTING COVERAGE

SELECTING COVERAGE

A new hire must select health coverage during the Initial Enrollment Period. The “Initial Enrollment Period” begins on the date the Employee becomes eligible and ends after 30 days of hire.

A new Employee must enroll within 30 days of hire. If the Employee does not enroll, the Employee will automatically be covered under the \$1,000 Deductible Plan with no Coverage for Dependents.

If an Employee enrolls a Dependent after the Initial 30-Day Enrollment Period without a bona fide family status change or special enrollment event, the Dependent will be considered a Late Entrant to the South Dakota State Employee Health Plan and must satisfy a waiting period before re-applying for coverage. Late entrants must enroll for coverage during Annual Enrollment. The effective date of coverage is July 1st. Pre-existing conditions exclusion periods may apply for Dependents age 19 or older.

Current Employees may elect or change coverage only during an Annual Enrollment Period through the electronic enrollment system, unless there has been a qualified change in family status. This means an Employee generally may not change the level of coverage, the plan election, or Dependent coverage election during the Plan Year.

Choosing a Coverage Level

An Eligible Employee may elect individual coverage and also may choose from six categories of Dependent coverage:

- (a) Employee plus spouse;
- (b) Employee plus child;
- (c) Employee plus 2 children;
- (d) Employee plus 3 or more children;
- (e) Employee plus spouse and 1 child; or
- (f) Employee plus spouse and 2 or more children.

The Employee must elect coverage in order to also enroll Dependents. If an Eligible Employee Opts-Out of coverage under the South Dakota State Employee Health Plan, he or she cannot elect healthcare coverage for any family member.

As a new hire or during Annual Enrollment, an Eligible Employee may choose to Opt-Out of the State Plan providing acceptable proof of group coverage elsewhere.

See “Late Entrants”, “Special Enrollment Period”, and “Family Status Changes” for more information on when you may elect coverage for you or your eligible Dependents.

WHEN COVERAGE BECOMES EFFECTIVE

Following initial enrollment, you and your enrolled Dependents' coverage becomes effective as follows:

Coverage is effective one month and one day from the date of hire.

In all cases, the actual coverage effective date will be contingent on receipt of all appropriate paperwork and required contributions.

Changes during annual enrollment are effective as follows:

In the event the Employee changes coverage during the Annual Enrollment Period, this change will be effective on the first day of the Plan Year if all the required paperwork is completed and approved. Approved changes are effective July 1st of each year.

OPTION NOT TO ELECT COVERAGE – (OPT-OUT)

Upon receipt of acceptable proof (i.e. a signed letter written on the official letterhead or a certificate of Creditable Coverage) that an Employee has Creditable Coverage through the spouse or another job, a newly hired Employee may Opt-Out of coverage under this Plan during the Initial Enrollment Period. Current Employees may Opt-Out of coverage during any subsequent Annual Enrollment Period. Eligible Dependent(s) are not covered under the Plan if the Employee Opts-Out of coverage.

Members who Opt Out of the health plan will receive an Opt Out credit of \$300. This credit is deposited into an Opt Out account with DAKOTACARE. Members may receive reimbursement of medical claims by submitting a Claim Form. The Claim Form is located online at <http://benefits.sd.gov>, choose Active Employees, scroll over Forms/Documents, click Forms/Documents, and click Claim Form.

NOTE: Other “acceptable group Health Coverage” does not include: Medicare, Medicaid, Indian Health Services, or services provided through the VA Hospital. If an Employee and/or Dependents Opt-Out of coverage and the Bureau of Human Resources is notified that the Employee and/or Dependents have lost the other coverage through no fault of his or her own, the State will reinstate coverage for the Employee and/or Dependents under the \$1,000 Deductible Plan. The Employee must contact the Bureau of Human Resources to request the necessary forms for enrolling or re-enrolling in the Plan. See “Late Entrants”.

Employees who elect to Opt-Out of Health Coverage are not eligible for COBRA continuation coverage or to continue coverage as a retiree.

REENROLLING IN THE PLAN

An Employee who Opts-Out of the South Dakota State Employee Health Plan can return to the Plan as a result of special enrollment or during any Annual Enrollment Period.

If the Employee and eligible Dependents lose the other group Health Coverage during the Plan Year through no fault (involuntary loss of coverage), the Employee and eligible Dependents may return to the South Dakota State Employee Health Plan under the \$1,000 Deductible Plan.

The Bureau of Human Resources must be notified within 60 days of losing the other coverage. To re-enroll, a certificate of Creditable Coverage from the other group health plan showing the effective and

ending dates of coverage under that Plan, as well as proof of loss of coverage must be provided. By law, employees must be allowed to return to the Plan if they lose group Health Coverage under another plan.

If the Employee does not notify BHR within this 60-day period, any Dependents will not be eligible for coverage until Annual Enrollment with an effective date of July 1st.

Note: Pre-existing conditions exclusion periods may apply for Dependents age 19 or older.

DUAL COVERAGE UNDER THIS PLAN

No person may be covered under the Plan at the same time as both an Employee and a Dependent or as a Dependent of more than one Employee. Either spouse can carry Dependent coverage.

If a Dependent has a break in coverage, a special enrollment event or a qualified family status change such as marriage, birth, or adoption must occur to allow the Dependent to re-enroll in the South Dakota State Employee Health Plan. If there is not a special enrollment or family status change event, the Dependent is considered a Late Entrant and a waiting period applies. Late entrants must enroll for coverage during Annual Enrollment. The effective date of coverage is July 1st. Pre-existing conditions exclusion periods may apply for Dependents age 19 or older.

FAMILY STATUS CHANGES

If the effective date is same as the date of the qualify event, coverage is effective on the payroll cycle nearest the 1st or the 15th of a month.

The only time a coverage change can be made during a Plan Year is within 60 days of a Special Enrollment Period or within 60 days of a qualifying event. Coverage changes include adding or dropping a Dependent from coverage or re-electing coverage for the Employee and/or his or her eligible Dependents upon approval from the Bureau of Human Resources.

Examples of qualified changes in family status include:

- (a) Marriage;
- (b) Divorce;
- (c) Death;
- (d) Birth, adoption, or placement for adoption of a child.

The coverage effective date will be contingent on receipt of all appropriate paperwork and required contributions nearest the 1st or 15th of the month.

In certain circumstances, the issuance of a Medical Support Order is also considered an acceptable Family Status Change. See “Words and Phrases” for the definition of “Medical Support Order”. Changes can also be made to Health Plan coverage during the Plan Year if eligible Dependents are covered by another company’s health plan and the Employee wants to remove them from, or add them to, the State Plan because they acquired or lost coverage during the spouse’s enrollment period. If the Bureau of Human Resources is notified later than 60 days, the Dependent will be considered a Late Entrant. Late entrants

must enroll for coverage during Annual Enrollment. The effective date of coverage is July 1st. Pre-existing conditions exclusion periods may apply for Dependents age 19 or older.

SPECIAL ENROLLMENT PERIODS

If the Employee declines enrollment for himself/herself or Dependents (including spouse) because of other health insurance coverage, the Member and Dependents will be able to enroll in this Plan if Family Status Change is received within 60 days, as a result of loss of coverage.

In addition, if an Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, Employee may enroll the dependents provided the Employee is covered under the Plan and Family Status Change is received within 60 days after the marriage, birth, adoption, or placement for adoption.

Involuntary losses of coverage are considered special enrollment situations if there is no more than a 63-day break in coverage, and include, but are not limited to, the following types of situations. Pre-existing conditions exclusion periods may apply for Dependents age 19 or older.

- The Employee is laid off,
- A company closes,
- An employer fails to pay timely contributions on behalf of the employee,
- Expiration of COBRA, or
- Enters a non-eligible status.

Some voluntary losses of coverage are portable and considered special enrollment situations. No waiting period applies:

- If there is no more than a 63-day break in coverage and
- The applicant is able to provide proof of continuous creditable Health Coverage from the time of initial eligibility with the South Dakota State Employee Health Plan to date of application for coverage.

Examples include, but are not limited to, the following types of situations:

- Quits,
- Retires,
- Enters a non-eligible status, or
- Is terminated.

Some examples of voluntary loss of coverage in which a waiting period is applied include, but are not limited to:

- The Employee failing to pay contributions for coverage in a timely manner,

- Increase in cost of coverage with another plan.

LATE ENTRANTS TO THE SOUTH DAKOTA STATE EMPLOYEE HEALTH PLAN

Employee and eligible Dependents are generally considered Late Entrants to the South Dakota State Employee Health Plan if the:

- New Employee does not apply for coverage within 30 days of date of hire,
- Current Employee applying for coverage because of a qualified family status change, does not report the change within 60 days of the event, or
- Employee elects to “Opt-Out” of the South Dakota State Employee Health Plan coverage and then enroll or re-enroll eligible dependents after voluntarily losing other group health plan coverage.

If the Employee does not enroll within this 60-day period, or voluntarily loses other health plan coverage, any eligible dependents will be considered Late Entrants and may enroll during Annual Enrollment with an effective date of July 1st. Pre-existing conditions exclusion periods may apply for Dependents age 19 or older.

CONTRIBUTION RATES (COST OF COVERAGE)

Employees will receive information about the cost for Health Coverage during annual enrollment or before enrolling as a new hire. Information may be obtained by contacting the Plan Administrator.

If the Employee is a non-tobacco user, the State of South Dakota pays the full cost of Employee coverage.

If the member or spouse is a tobacco user, a tobacco user fee will be applied.

The Employee pays the cost of coverage for Dependents under the Health Plan. Dependent spouse contribution rates are based on age of the spouse.

The Plan Administrator reserves the right to adjust contribution rates during the Plan Year.

Employees and eligible Dependents who elect continuation of coverage pay the cost for COBRA/Retiree contribution rates. To view Active Contribution Rates, visit <http://benefits.sd.gov/Rates.aspx>. To view COBRA/Retiree Contribution Rates, visit <http://benefits.sd.gov/Ratesrc.aspx>.

MAJOR MEDICAL BENEFITS

The following provisions apply to the \$500 Deductible Plan, the \$1,000 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), then multiplying the remainder by the applicable Coinsurance amounts that apply:

- (a) Covered Hospital charges Incurred by the Member during each continuous period of disability;
- (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);

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) Emergency Room Visit Copayments;
- (e) Penalties for not obtaining a second opinion when required;
- (f) Penalties Incurred when Pre-authorization is not arranged when required; and
- (g) Prescription drug Copayments. Prescription drug Copayments for the \$500 Deductible Plan and \$1,000 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, air ambulances, and private duty nursing, may be reviewed after treatment is provided.

Services that are not Medically Necessary will not be covered by the Plan. Diagnostic tests, lab work, or similar services are not considered Medically Necessary if they are performed solely because the Patient has a family history of a disease or other condition. In the same way, genetic testing used to predetermine or predict a future medical condition is not considered Medically Necessary for the treatment or mitigation of an existing medical condition.

Pre-authorization by HMP 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), in certain instances.
- (a) Charges for the following services qualify as covered Hospital charges if the services are for a Hospital stay or days of inpatient care at an Extended Care Facility (ECF) or Acute Rehabilitation Facility. Care provided in an ECF or Acute Rehabilitation Facility must be ordered by a Physician and in place of a Hospital stay.
- 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;
 - Blood and blood plasma (administration of services and supplies covered when charged by the Hospital, ECF, or Acute Rehabilitation Facility-special nursing and Physician's services not included).
 - 3) Medically Necessary covered medications prescribed and administered during an approved confinement.
- (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.
 - 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. Air ambulance services will be reviewed retrospectively for 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.

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.

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.)
- 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
- Stammering, stuttering

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

- 14) Initial rental or purchase, at the Plan option, of Medically Necessary Durable Medical Equipment, such as 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.
 - 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. See "Benefit Exclusions" for exceptions.
- 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.
 - 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.
- (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; and
 - 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;
- 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 from HMP 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 by HMP and provided by a United Resources Network (URN)/ Optum Health center of excellence or other approved facility as determined by the Plan. If a member chooses a facility other than one approved by the State, the member will be responsible for any cost differences. The Plan will only pay the amount they would have paid for the approved facility. The member is responsible for all remaining charges.

- (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.
 - 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 Employees and Spouses:
- 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).
 - 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.
- (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, schizo affective 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.
- 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 or hepatitis tests that are Medically Necessary for diagnosis and treatment.
- (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 malabsorption 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.

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, which are experimental in nature or drugs that are not approved by the Food and Drug Administration (FDA) or covered by the Plan.
- (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) Amounts above what the Plan would have paid an approved provider, service, or supply. (e.g., an out-of-state Hospital for non-emergency admission or a facility that has not negotiated with the State to accept a set payment amount for certain outpatient procedures or tests).
- (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; or
- (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) General, routine health exams (including routine annual physicals, school physicals, sports or employment-related physicals).
- (s) Routine screenings for HIV or 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."
- (v) Personal comfort or convenience items while Hospitalized include:
 - TV usage,
 - telephone usage,
- (w) Durable medical equipment prescribed solely for convenience or because it is the most recent model.
 - 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 the Pregnancy, infertility diagnosis, or infertility treatment for a Dependent child;
- (jj) Routine foot care, except Medically Necessary custom fit orthotic devices.
- (kk) Transportation or lodging, except as provided under ambulance 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. (See "(ii)" in this section.)
- (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) Molecular genetic testing, related genetic counseling, or genetic disease screening, including panels for targeted and population based screening, except when all of the following requirements are met
 - a) the member displays clinical features of or is at direct risk of inheriting the mutation in question (pre-symptomatic); and
 - b) after history, physical examination, pedigree analysis, genetic counseling, and completion of conventional diagnostic studies, a definitive diagnosis remains uncertain; and
 - c) the results of the genetic test will impact the medical management of, and treatment being delivered to, the member.

Qualified genetic counseling services must be provided by a Participating Licensed Genetic Counselor. Prior approval is needed for all services.

- (bbb) Speech, occupational, or physical therapy exceeding the Plan benefit maximum; provided by the school system or other organization/entity; provided without a doctor's prescription; or begins more than 30 days after being prescribed by a Physician. See "Covered Charges" for exceptions.
- (ccc) Charges for smoking cessation classes, unless offered or sponsored by the South Dakota State Employee Health Plan.
- (ddd) Charges for missed medical appointments.
- (eee) 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.
- (fff) 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.
 - 2) Charges for Custodial Care.
- (ggg) Outpatient prescription drugs except as covered by CVS Caremark under the pharmacy component of the Health Plan.
- (hhh) Applied Behavior Analysis (ABA) therapy or related socialization or behavior modification therapies
- (iii) 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.
- (jjj) Services, supplies, or medications related to or treatment in connection with sexual dysfunction or sexual inadequacy, whether organic or psychological in nature.

STATE SET PAYMENT AMOUNTS AND STATE PREFERRED FACILITIES/PROVIDERS

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.

SET PAYMENT AMOUNTS

This is the amount the State negotiated with the facility or provider for the particular service. The State will not consider any more than this amount as eligible for benefits when the service was rendered at a non State Preferred facility or provider.

STATE PREFERRED CONTRACTED FACILITIES

State preferred contracted facilities are not the same as the DAKOTACARE Network. In order to manage the expenses of the health plan, the State negotiates set payment amounts via a bid process. It is important for members to verify benefits if they would like to have the lowest out of pocket expense.

UTILIZING A NON-PREFERRED CONTRACTED FACILITIES

Utilizing a Non-preferred contracted facility could result in significant non-covered Out-of -Pocket costs. Example, a member has a CT scan at a non State preferred provider that happens to be a DAKOTACARE participating provider:

Billed Charge	\$1,373.00
DAKOTACARE discount	<u>373.00</u> – provider write off amount
	\$1,000.00
State Set Payment Rate	<u>608.00</u> – Member benefits are applied to this amount
Member Non-Covered Amount	\$ 392.00 – this amount is an exclusion of the plan and not applicable to the member out of pocket
Benefit Application	\$608.00 – State Set Payment Rate is the benefit eligible amount
Member Deductible	<u>500.00</u>
Balance applies to Coinsurance	108.00x 75% = Plan Pays \$81.00 Member Coins \$27.00
Claim Balance:	
Member Deductible	\$500.00
Member Coinsurance	27.00
Plan Payment	<u>81.00</u>
	\$608.00
Member Non-Covered Amt	<u>392.00</u>
	1,000.00+373.00 (discount) = \$1373.00
Member Responsibility	\$500+27+392=\$1,219.00

The same CT at a State Preferred Set Payment Rate Provider would be covered as follows:

Billed Charge	\$1,373.00
State Set Payment Rate	<u>608.00 – Benefit Eligible Amount</u>
	\$ 765.00 – provider write off

Benefit Application	\$608.00
Member Deductible	\$500.00
Member Coinsurance	27.00
Plan Payment	<u>81.00</u>
	\$608.00

Member Responsibility \$527.00

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.

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

Coverage for Tier 1					
\$500 Deductible Plan		\$1,000 Deductible Plan		\$1,800 Deductible Plan with HSA	
Tier 1*	Non-Tier 1	Tier 1*	Non-Tier 1	Tier 1*	Non-Tier 1
\$500 per person Deductible	\$500 per person Deductible	\$1,000 per person Deductible	\$1,000 per person Deductible	\$1,800 per person Deductible	\$1,800 per person Deductible
25% Coinsurance	25% Coinsurance Network Provider	25% Coinsurance	25% Coinsurance Network Provider	25% Coinsurance	25% Coinsurance Network Provider
\$2,500 Out-of-pocket maximum	35% Coinsurance Out-of-Network Provider \$5,000 Out-of-pocket maximum	\$3,500 Out-of-pocket maximum	35% Coinsurance Out-of-Network Provider \$5,000 Out-of-pocket maximum	\$3,600 Out-of-pocket maximum single \$7,200 Out-of-pocket maximum family	35% Coinsurance Out-of-Network Provider \$5,400 Out-of-pocket maximum single \$10,800 Out-of-pocket maximum family

Tier 1 Facilities, Services and Providers for FY14		
Sanford	Avera	Sioux Falls Specialty Hospital
Cardiac Orthopedic Bariatric	Renal Care	Gastroenterology
Must be a Sanford provider	Must be an Avera provider	Must be an approved 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.*

SET PAYMENT FOR CT/MRI/PET SCANS

CT/MRI/PET Scan tests are covered up to the set payment amount the State has negotiated. The State has contracted with a group of providers who have agreed to accept a set fee as payment in full for CT/MRI/PET Scans performed at their facilities or at various locations serviced by their mobile units.

All CT, MRI, and PET Scans require pre-authorization.

Emergency CT/MRI/PET Scans will be reviewed after the test is provided.

MEMBER RESPONSIBILITY FOR CT/MRI/PET SCANS

Plan	State Preferred Contracted Facility*	State Non-Contracted Facility**
\$500 Deductible Plan		
Deductible	\$500	\$500
Coinsurance (Facility)	25%	25%
Cost Variance between Contracted and Non-Contracted Facility***	N/A	Yes, total difference.
\$1,000 Deductible Plan		
Deductible	\$1,000	\$1,000
Coinsurance (Facility)	25%	25%
Cost Variance between Contracted and Non-Contracted Facility***	N/A	Yes, total difference.
\$1,800 Deductible Plan		
Deductible	\$1,800	\$1,800
Coinsurance (Facility)	25%	25%
Cost Variance between Contracted and Non-Contracted Facility***	N/A	Yes, total difference.

* To view the preferred contracted facility listing, visit <http://benefits.sd.gov/Files/2014/Forms/FY14contractedfacility.pdf>

** Must be DAKOTACARE Provider.

*** Does not apply to Out-of-Pocket Maximum.

The Plan Administrator reserves the right to review services received by plan Members and to determine the appropriate defined benefit for those services. The set payment amounts for these tests may change periodically due to rising healthcare costs overall or during negotiations with the providers. The Plan Administrator reserves the right to adjust set payment fees and global fees during any Plan Year.

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 .

CONTINUOUS PERIOD OF ILLNESS OR INJURY

Successive Hospital stays are deemed to occur in the same continuous period of illness or Injury, unless the Plan Administrator receives satisfactory evidence that the later stay:

- (a) Is due to causes not related to those of the earlier stay;
- (b) Occurs after full recovery from causes of the earlier stay; or
- (c) Is for treatment of all other conditions — is separated from the earlier stay by 90 days or more.

MANAGED CARE PROGRAM

The State of South Dakota contracts with Health Management Partners (HMP) to provide managed care services and utilization review through a managed care program.

If the guidelines of the Managed Care Program are not followed, benefits payable under the Plan may be reduced or denied.

In addition, after reviewing medical services received by a Member, the Plan Administrator or its designee may find that healthcare services or prescription medications are being prescribed or received in a harmful quantity or manner, with harmful frequency, or that they are not Medically Necessary. If this is found to be the case, the Plan Administrator or its designee, after appropriate investigation, may terminate plan coverage for those services or prescription medications. The Plan Administrator may require the Member to select a single participating Physician, participating Hospital, participating pharmacy, or other participating healthcare provider for individual management and coordination of all future health services.

PRE-AUTHORIZATION OR PRE-NOTIFICATION OF SERVICES-IN-STATE

The Member or Member representative must call HMP before any non-emergency Hospital Admission and before receiving certain services to provide details of the proposed Hospital Admission, service, or treatment. The authorization should be made as soon as possible after the surgery or service has been prescribed or scheduled to allow HMP enough time to explore medical necessity and pricing alternatives. Approval of Plan benefits requires adequate timing for authorization and cooperation from the provider and/or the facility. To view the Pre-authorization listing, visit <http://benefits.sd.gov/Forms.aspx> and choose FY14 Pre-authorization listing.

Pre-authorization is required for certain prescriptions to be covered under the Prescription Drug Plan. Providers can submit the pharmacy prescription pre-authorization request to www.dkc-pa.com.

In the case of an emergency admission, the authorization must be made within 48 hours, if possible, after such admission. Certain other services (such as emergency room services) may be authorized on a retroactive basis, after treatment is provided. A call to HMP will initiate the review process.

The time limits described above may be waived if it is shown that:

- (a) It was not reasonably possible to provide such notification within the time limit which applies; and
- (b) Notification was provided as soon as was reasonably possible.

Pre-authorization by HMP does not guarantee coverage under the Plan. The services must fall within the South Dakota State Employee Health 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.

DAKOTACARE providers will initiate required Pre-authorization review processes for the Member.

If a Member visits a non-DAKOTACARE provider, the Member or a Member representative must contact HMP for review and Pre-authorization of services.

PRE-AUTHORIZATION OF SERVICES OUT-OF-STATE

For all Health Plan options, members are required to obtain Pre-authorization for any health care received outside the state of South Dakota (e.g., Mayo Clinic and University of Colorado).

The Member or the Member representative must call Health Management Partners (HMP) before any non-emergency Hospital Admission and before receiving certain services to provide details of the proposed Hospital Admission, service, or treatment. This call should be made as soon as possible after the surgery or service has been prescribed or scheduled to allow HMP enough time to explore medical necessity and pricing alternatives. Approval of Plan benefits requires adequate timing for authorization and cooperation from the provider and/or the facility.

In the case of an emergency admission, authorization must be made within 48 hours, if possible, after such admission. Certain other services (such as emergency room services) may be authorized on a retroactive basis, after treatment is provided. A call to HMP will initiate the review process.

The time limits described above may be waived if it is shown that:

- (a) It was not reasonably possible to provide such notification within the time limit which applies; and
- (b) Notification was provided as soon as was reasonably possible.

Pre-authorization by HMP does not guarantee coverage under the Plan. The services must fall within the South Dakota State Employee Health 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.

If a Member visits a non-DAKOTACARE provider, the Member or a Member representative must contact HMP for review and Pre-authorization of services.

FAILURE TO MEET PRE-AUTHORIZATION REQUIREMENTS

If a Managed Care Program notification requirement is not satisfied when a Member is admitted to a Hospital or receives certain medical services, the Plan Administrator may reduce or deny benefits in connection with the Hospital Admission or service.

If a Member elects to receive services even though the services have not been allowed by HMP, the Plan will not pay benefits for those services, or will provide benefits at a lower level, depending on whether the service is covered by the Plan.

For example, if HMP determines that a portion of a Hospital stay is not Medically Necessary or if any day is not authorized as appropriate for that condition or treatment, all charges for that day will not be considered a covered charge. No benefits will be paid for all charges for that day.

SERVICES REQUIRING PRE-AUTHORIZATION

Procedures Costing More Than \$25,000

All procedures for which professional and/or facility charges will total (or are expected to total) more than \$25,000 will require Pre-authorization and/or a second opinion. Regardless of cost, the following services require Pre-authorization and/or second opinions.

Admissions

- (a) Assistant surgical services (whether performed inpatient or outpatient);
- (b) Hospice;
- (c) Mental health and chemical dependency, including partial or half-time residential treatment;
- (d) Non-emergency admissions to out-of-state Hospitals;
- (e) Observation services;
- (f) Out-of-network services;
- (g) Rehabilitation;
- (h) Skilled nursing;
- (i) Surgical, non-surgical (medical, mental health, substance abuse); and
- (j) Transplant services.

NOTE: Pre-authorization is not required for the minimum postpartum length of stay required by the Newborns' and Mothers Health Protection Act of 1996. Days in excess of the accepted length of stay require Pre-authorization.

Other Services

- (a) Ambulatory infusion;
- (b) Cardiac catheterization;
- (c) Chelation Therapy;
- (d) Chemical dependency and substance abuse treatment;
- (e) Cardiac self-management training and education;
- (f) Genetic Testing
- (g) Home health services, including home infusion, pain management, and Hospice;

- (h) Physical, occupational, or speech therapy;
- (i) MRI, MRA, CTA, CT, and PET Scans;
- (j) Observation services;
- (k) Out-of-network services;
- (l) Rehabilitation;
- (m) Maternity Ultrasounds
- (n) Kidney Dialysis and related services
- (o) Temporomandibular Joint Syndrome (TMJ) treatment
- (p) Select drugs must be Pre-authorized by DAKOTACARE. To view the list for drugs that require Pre-authorization, visit <http://benefits.sd.gov/Forms.aspx> and FY14 Pre-authorization Listing.
- (q) Select Durable Medical Equipment, services and supplies:
 - 1) Compression pumps;
 - 2) CGMS (continuous glucose monitoring system);
 - 3) CPAP, CPAP with humidifiers, Bi-PAP (continuous positive airway pressure);
 - 4) Colonoscopies (does not apply to preventive colonoscopies)
 - 5) Continuous Positive Motion (CPM) machine;
 - 6) Custom made braces over \$1,000;
 - 7) DME exceeding \$1,000;
 - 8) Electrical stimulation for urinary/bowel incontinence;
 - 9) Erect aid;
 - 10) Feeding pump (pump, tube, and kit);
 - 11) Hospital beds;
 - 12) Insulin pumps;
 - 13) Neuromuscular electrical stimulators;
 - 14) Negative pressure wound therapy pump;

- 15) Osteogenic stimulator (bone growth stimulator) — authorization requires a Physician's documented history of poor bone healing and at least one risk factor (such as multi-level fusion, smoker, or diabetes) ;
 - 16) Oximeters;
 - 17) Oxygen (includes the oxygen carrier);
 - 18) Percussors;
 - 19) Pressure relief mattress;
 - 20) Prosthetics;
 - 21) SAD (Seasonal Affective Disorder) Lites;
 - 22) Speech Devices;
 - 23) Suction pumps;
 - 24) TENS (transcutaneous electrical nerve stimulator);
 - 25) Terbutaline pumps;
 - 26) Upper GI and Endoscopies
 - 27) Uterine monitor;
 - 28) Ventilator;
 - 26) Wheelchairs for purchase.
- (r) Surgical procedures performed in the outpatient department of ambulatory surgical centers, Hospitals, or specialty Hospitals; e.g. Vertebroplasty, Epidural Blocks, Kyphoplasty, SCS trial and implantation.
- (s) Transplant services;

If during the initial review, Health Management Partners (HMP) finds the proposed treatment or admission to be inconsistent with treatment guidelines, the requesting provider or facility will be notified by faxed letter immediately. The requesting party will be given the opportunity to request a conversation with the HMP Physician to discuss the case. If the two Physicians are unable to negotiate an appropriate treatment plan, the denial will stand. The member and provider have the opportunity to appeal the determination

Covered services received on an emergency basis outside the country do not require Pre-authorization.

NOTE: Outpatient surgery claims may be reviewed for medical necessity after claims are submitted. Outpatient surgeries or procedures performed solely for cosmetic reasons or that are not Medically Necessary will not be covered by the Plan.

SECOND OPINIONS

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 Plan Managed Care Program. Voluntary second opinions are subject to the same Deductible 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 (such as non-emergency surgical procedures) when HMP has cause to believe there is an effective and equivalent alternative to the original medical/surgical opinion. Non-emergency surgical procedures may include, but are not limited to, gastric bypass, sinus surgery, or anterior/lateral disc fusion. Second opinions are also required for surgical procedures that must be redone due to the Member not following Physician instructions.

Services will be covered as follows when a second opinion is required:

- 1) The Plan will cover 100% of the required second opinion consultations, including Office Visits, pre-authorized tests, and mileage costs. In requiring a second opinion, the Plan Administrator will consider medical necessity, cost (e.g., procedures/services above \$25,000), location, diagnosis, and other related factors concerning the medical condition of the covered Member. Failure to obtain a required second opinion reduces coverage for the service/procedure to 50%. The additional out-of-pocket costs for the service/procedure will not apply to the annual medical Out-of-Pocket Maximum.
- 2) If Pre-authorization review and/or the second opinion process indicate that a Medically Necessary procedure can be beneficially performed at an In-Network facility, payment will be limited to the contracted fee at that facility. If the Member chooses another facility, benefit will be processed as Out-of-Network and Usual, Customary, and Reasonable will apply. The charges over Usual, Customary, and Reasonable will not apply to the annual medical Out-of-Pocket Maximum.
- 3) If it is determined during Pre-authorization review or the second opinion process that a procedure must be redone and is necessary because Physician instructions were not followed, the covered individual is responsible for 100% of the cost of the second procedure/surgery. The cost of this surgery does not apply to the annual medical Out-of-Pocket Maximum.

See “Services Requiring Pre-authorization” and “Services Requiring Second Opinions” for additional information about specific services.

SERVICES REQUIRING SECOND OPINIONS

The following services may require second opinions:

- Anterior / Lateral disc fusion,
- Gastric bypass surgery,
- Sinus surgery,
- Surgery that is redone because the Member didn't follow physician orders, and
- As determined by HMP, Plan Medical Management vendor.

UTILIZATION REVIEW SERVICES

Inpatient Services

Once the Hospital admission has been reviewed, HMP will provide confirmation of the approval to the doctor, the Hospital, the Claims Administrator, and/or the Bureau of Human Resources. HMP will remain in contact with the facility throughout the Hospitalization to monitor Member progress, and may explore alternative treatment settings or the need for additional days in the Hospital.

Emergency Room Services

Emergency Room (ER) Services will be retrospectively reviewed for appropriate utilization. Members who utilize the emergency room will receive contact from HMP for following up including review of discharge instructions. Members may be subject to a reduction of ER benefits for inappropriate usage. Continued inappropriate ER usage may result in a 50% reduction in benefits or charges not being covered by the health plan. Reduced benefits and non-covered amounts are the responsibility of the member and not applicable to maximum out of pocket amounts.

MEDICAL CASE MANAGEMENT

Case management is a collaborative process that provides Members with health management support through a variety of coordinated programs. It is offered as a confidential and free program to Members who are experiencing complex health issues or challenges in meeting their health care goals. HMP provides case management for South Dakota State Employee Health Plan Members.

HMP case managers are registered nurses who provide Members with information and direction about health issues, Health Coverage, available community resources such as help with transportation, and much more. They can help make sure the Member is getting the best use of the covered services available to them.

Case Management is intended to support the Physician's plan of care. The case manager may contact the Member's Physician office to develop a rapport to support ongoing collaboration throughout the time the Member is in the program.

The case manager will:

- Review Member's current condition and history;
- Identify problems and offer education;
- Work with the Member to set goals that address problems;
- Suggest actions to reach goals;
- Measure progress towards goals; and
- Discharge the Member from case management when goals have been met.

Health conditions, which may be referred to a case manager, include but are not limited to:

- Active treatment of cancers or transplants;

- Depression or chemical dependency;
- Chronic diseases or chronic pain;
- Multiple sclerosis;
- Catastrophic events such as traumatic injuries;
- Readmissions to Hospital;
- High cost indications; and
- Neonatal Intensive Care Unit (NICU) admissions.

INTENSIVE MEDICAL CASE MANAGEMENT

Members dealing with complex medical conditions may be invited to participate in an Intensive Medical Case Management Program. Participation is encouraged as these programs have positive outcomes for members and providers. Members and their designee (if applicable) are provided access to a qualified Intensive Medical Case Manager that will offer assistance, additional education, and act as a liaison with the member and their treatment team to offer additional support and care facilitation.

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.

If a member chooses a facility other than one approved by the State, the member will be responsible for any cost differences. The Plan will only pay the amount they would have paid for the approved facility. The member is responsible for all remaining charges.

When non-DAKOTACARE or out-of-state providers are used and charges are more than these accepted amounts, the Plan will not cover the amount above the Usual, Customary, and Reasonable (UCR) or MAC amount, even if the Out-of-Pocket Maximum is met. The Member is responsible for paying the excess charges.

DAKOTACARE provides Intensive Medical Case Management for South Dakota State Employee Health Plan Members.

BARIATRIC SURGERY

Bariatric surgery will be covered under the health plan when the Member meets the eligibility criteria and complies with the management plan. Guidelines to determine eligibility for bariatric surgery are as follows:

- The Member has a Body Mass Index (BMI) of 40 or greater or Member has a BMI of 35 or greater and a clinically serious condition exists (e.g., sleep apnea, diabetes, high blood pressure, arthritis).
- The Member must have failed non-surgical weight loss through a Physician-approved program with or without pharmacotherapy.
- No specifically correctable cause for obesity (e.g., an endocrine disorder) has been identified.
- Member has achieved full adult stature as determined by Physician

Participation in the Bariatric Management Plan:

- Member must agree to participate in the plan's four-phase health management program for twelve months after bariatric surgery.
 - **Phase I** - Member must receive evaluation and treatment from a facility contracted for bariatric surgery.
 - **Phase II** - The Member must agree to participate in a multidisciplinary program for weight loss and weight management. Weight gain of more than five pounds from the weight submitted during Phase I will be considered non-compliance and the Member will become ineligible for surgery.
 - **Phase III** – Bariatric surgery approval and completion.
 - **Phase IV**- Members who successfully participate in the program will be eligible for 1 (one) skin reduction surgery twelve months after surgery and once a stable weight has been achieved and maintained.
- If a Member becomes ineligible for surgery due to non-compliance, they may reapply to the program after twelve months. However, any consultations done during the first time frame will have to be done again and none of the cost of the consultations will be covered by the plan.
- The medical appropriateness of the type of surgery will be evaluated by the Medical Director.

To enroll in the program or for detailed information about the four-phase program, contact the Bariatric Management Program at Health Management Partners:

- Email: weightloss@hmpsd.com
- Call toll-free: 1-866-330-9886

PRESCRIPTION DRUG PLAN

The Plan Administrator will pay a portion of the cost of covered prescriptions. Maximum benefits are paid when prescriptions are filled through the CVS Caremark network pharmacies .

To view the Formulary List, visit <http://benefits.sd.gov/Forms.aspx> and choose FY14 Formulary.

All prescriptions are subject to the coverage guidelines and limitations as determined by the Plan.

CVS CAREMARK NETWORK PHARMACIES

Participating pharmacies submit claims and are reimbursed by the Plan for charges allowed under the Pharmacy Network contract. If enrolled in the \$500 Deductible Plan or the \$1,000 Deductible Plan, there is a Plan year \$50 Deductible per Member for filled prescriptions. When the \$50 Deductible per Member is satisfied, the Member pays a Copayment for each covered prescription.

If the Member purchases a prescription at a nonparticipating pharmacy, or does not show a Member ID card to the pharmacist, the Member will be required to pay the full price for the prescription at the time of purchase and then submit a claim for reimbursement. Reimbursement is limited to the CVS Caremark contracted rates cost, minus the applicable Copayments and Deductible. Required claim forms can be obtained from the Bureau of Human Resources or online at <http://benefits.sd.gov>, click Active Employee, scroll over Forms/Documents, choose Forms/Documents, and choose Claim Form

PHARMACY DEDUCTIBLE PER MEMBER PER PLAN YEAR

A \$50 Deductible per Member per Plan year exists on prescription drug coverage for those enrolled in the \$500 Deductible Plan or the \$1,000 Deductible Plan. Before pharmacy benefits are paid, each Member must satisfy the \$50 Deductible. Once the pharmacy Deductible is met, applicable Copayments under the Five-Tier Prescription Drug Plan will apply.

For the \$1,800 Deductible Plan (HSA Compatible), special rules affect this Plan.

COPAYMENTS

When the \$50 Deductible is satisfied, member is responsible for applicable Copayments for covered prescriptions. If the price is less than the defined Copayment, you will pay the lesser of the two amounts.

FIVE-TIER PRESCRIPTION DRUG PLAN

The State of South Dakota offers coverage for generic medications and formulary brand products. Non-formulary products are not covered.

When enrolled in the \$500 Deductible Plan or the \$1,000 Deductible Plan, the State of South Dakota offers a Five-Tier Prescription Drug Plan with various levels of Copayment for each tier. The tiers are:

PHARMACY NETWORK PRESCRIPTION BENEFITS		
Tier	30 day supply	31-90 day supply
Tier 1-Generic	\$7	\$14
Tier 2-Brand Preferred	\$32	\$50
Tier 3-Brand Non-Preferred	\$60	\$85
Tier 4-Specialty Preferred	\$60	N/A
Tier 5-Specialty Non-Preferred	\$85	N/A

SPECIAL RULES FOR THE \$1,800 DEDUCTIBLE PLAN

Under the \$1,800 Deductible Plan, a single \$1,800 Deductible and \$3,600 family Deductible apply to both medical expenses and prescription drug expenses combined.

When enrolled in the \$1,800 Deductible (HSA Compatible), there is no pharmacy Deductible, no tiered Copayments, and no pharmacy Out-of-Pocket Maximums. Member pays Deductible and Coinsurance until they satisfy the Out-of-Pocket Maximums.

PHARMACY OUT-OF-POCKET MAXIMUMS

Under the pharmacy Plan, there is a separate Out-of-Pocket Maximum for prescriptions. Pharmacy Copayments or other prescription drug costs do not apply to the medical out-of-pocket Deductible or medical Out-of-Pocket Maximum.

The maximum annual cost per Plan Year for covered medications for those enrolled in the \$500 Deductible Plan or \$1,000 Deductible Plan is:

- (a) \$1,000 per Member; and
- (b) \$2,500 per family of three or more. No one family member is eligible to meet more than the per Member Out-of-Pocket Maximum each Plan Year. The family Out-of-Pocket Maximum is satisfied when at least three family members have prescription drug expenses totaling the \$2,500 Out-of-Pocket Maximum. If a family has met the Out-of-Pocket Maximum for the year, a family member does not have to pay the \$50 deductible.

The pharmacy Out-of-Pocket Maximum includes the \$50 Deductible per Plan year and pharmacy Copayments.

The pharmacy Out-of-Pocket Maximum does not include:

- a. ancillary charges (the difference in cost between brand and generic drugs when purchasing a brand name drug when a generic is available),
- b. excess amounts paid at nonparticipating pharmacies,
- c. charges which are not covered by the Plan, or
- d. penalties for not pre-authorizing when required.

For the \$1,800 Deductible Plan (HSA Compatible), special rules affect this Plan.

COVERED PRESCRIPTIONS

Generally, the following are covered benefits:

- (a) Coverage is limited to the Plan formulary .
- (b) Prescriptions prescribed by a licensed provider, that require a prescription, either by federal or state law
- (c) DESI drugs (drugs in use prior to 1962 that have been permitted to remain on the market while evidence of their effectiveness is reviewed under the FDA's Drug Efficacy Study Implementation [DESI] program)
- (d) Compounded medications, submitted with a valid National Drug Code (NDC) for a legend medication
- (e) Insulin and other diabetic supplies which are prescribed by a licensed provider
- (f) Legend smoking cessation aids which are approved by the Plan Administrator (Limited to a 180-day lifetime supply)
- (g) Legend prenatal vitamins, excluding coverage for dependents
- (h) Legend pediatric fluoride vitamins
- (i) Oral/topical Contraceptives, excluding emergency contraceptives
- (j) Drugs that are self-administered
- (k) Fertility agents when Medically Necessary (up to the \$3,000 maximum pharmacy benefit) as determined by HMP

GENERIC POLICY

If a generic drug is available, and a Member chooses to take the brand product, the Member will be responsible for the ancillary charge. The ancillary charge is the difference in cost between brand and generic drugs when purchasing a brand name drug when a generic is available,

PRESCRIPTION DRUG PLAN EXCLUSIONS

The following are excluded from coverage unless specifically listed as a benefit under “Covered Drugs”:

- (a) Non-formulary medications
- (b) Non-legend drugs, including any over-the-counter (OTC) medications
- (c) Contraceptive jellies, creams, foams, or devices
- (d) Blood glucose monitors, diabetic swabs and calibration solutions
- (e) Emergency contraceptives
- (f) Injectable medications which are not considered self-injectable
- (g) All vitamins, except as noted under “Covered Drugs”
- (h) All Durable Medical Equipment (DME); except as noted for diabetic supplies
- (i) Prescriptions used for cosmetic purposes
- (j) Drugs labeled “Caution-limited by Federal law to investigational use,” or experimental medications that do not have NDC numbers even though a charge is made to the Member.
- (k) Charges for prescription drugs that exceed the CVS Caremark contracted rate
- (l) Medication which is to be taken by or administered to a Member, in whole or in part, while a Patient in a licensed Hospital, rest home, sanitarium, Extended Care Facility, skilled nursing facility, convalescent Hospital, nursing home, or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals
NOTE: Benefits for covered medications administered during an approved inpatient confinement are payable under the South Dakota State Employee Health Plan.
- (m) Charges for the administration or injection of any drug. Within the provisions of Plan coverage, these drugs, services, or supplies may be covered under the South Dakota State Employee Health Plan
- (n) Drugs used for indications not approved by the FDA
- (o) Legend drugs with OTC equivalents
- (p) Homeopathic or nutritional supplements (or combination of these with legend drugs)
- (q) Prescription medications obtained by illegal means
- (r) Replacement of supplies or medications that are lost, damaged, stolen, or used inappropriately including medications determined to be abused or otherwise misused.
- (s) Prescriptions used to treat Erectile Dysfunction and Cialis for BPH

LIMITS TO BENEFITS

Insulin and Needles /Syringes (including prefilled syringes)	Covered under one Copayment if purchased at the same time; 31-90 day supply per Copayment. If syringes are purchased separately from the insulin, they are covered under a separate Copayment.
Diabetic Test Strips	Covered under one Copayment for each 90-day supply.
Lancets	Covered under one Copayment. If lancets are purchased at same time as blood glucose test strips, only one Copayment applies.
Oral Contraceptives and Hormonal Products	Covered under one Copayment for a 90-day supply of eligible drugs.
Legend Smoking Cessation Aids which are approved by the Plan Administrator	Covered under one Copayment for up to a 30-day supply; benefits limited to a 180-day Benefit Maximum per Plan Member.
Prenatal Vitamins	Covered under one Copayment for each 90-day supply.
Allergy Medications	Covered under one Copayment for up to a 90-day supply of eligible drugs.
Allergy Serum	Allergy serum should be submitted to DAKOTACARE for processing. Your Physician should submit the claim like any other claim. You will be responsible for a medical copayment. Charges for administering the serum or the Office Visit are covered under the Health Plan.

REFILLS AND MAINTENANCE DRUGS

The Plan covers prescriptions, with a Copayment due when the prescription is filled. The dispensing limit for an acute condition is a 30-day supply per Copayment. The Plan will also cover up to a 90-day supply of “maintenance” drugs.

Maintenance drugs are prescribed for chronic, long-term conditions and are taken on a regular basis. Examples of chronic conditions are high blood pressure, high cholesterol, diabetes, and epilepsy. Drugs on a maintenance list are well-established medications with proven history of safety and efficacy. These drugs are typically considered first-line therapies. Medications listed on the Maintenance Drug list are available for three-month supplies.

For the current maintenance list, visit <http://benefits.sd.gov>, choose Active Employee, scroll over Forms/Documents, choose Forms and Document, and click Maintenance Drug List. The maintenance list is updated quarterly.

EARLY REFILL POLICY

A minimum of 75% of the medication must be used before a refill will be allowed. In a special circumstance of a Member needing to refill the medication before leaving on vacation, the Member may have one prescription refilled early per Plan Year.

In these situations, the Member should contact the Benefits Program at 773.3148 or 877.573.7347 for pre-authorization.

DRUGS REQUIRING PRE-AUTHORIZATION

The Member's Physician must contact DAKOTACARE at www.dkc-pa.com to arrange for Pre-authorization if one of these drugs is prescribed. For the current Pre-authorization list, visit <http://benefits.sd.gov>, choose Active Employee, scroll over Forms/Documents, choose Forms and Document, and click Pre-authorization list. The Pre-authorization list is updated without notice.

STEP THERAPY PROGRAMS

Step therapy programs are implemented on certain therapeutic classes of drugs. The programs are designed to have Members begin with the most cost-effective and safest drug available (known as first-line drug therapy). The step therapy program will allow for more costly and higher-risk drug therapies if a member fails the first-line drug therapy prescribed. The goal of these programs is to control costs and minimize side effects (from medications) that a Member may experience. To view the list of current step therapy programs, visit <http://benefits.sd.gov>, choose Active Employee, scroll over Forms/Documents, choose Forms/Documents, and click FY14 Pre-authorization Listing.

HOME DELIVERY PRESCRIPTION PROGRAM

Members may use the CVS Caremark Home Delivery Prescription Program when they need to fill or refill up to a 90-day supply of certain maintenance drugs. The same Copayments apply to mail-order pharmacy as the retail pharmacy.

SUBMITTING CLAIMS

If a Member visits a nonparticipating pharmacy, or does not present a Member ID card, the Member must submit a claim for reimbursement to the pharmacy network's Claims Administrator within one year from the end of the Plan Year.

Reimbursement is limited to the State cost had the Member used a participating pharmacy, minus the applicable Copayments.

NOTE: Prescription drugs administered in a Physician's office (e.g., an injection of an allergy serum) also require the Member to file a claim for reimbursement. The Member should pay the provider when receiving this service.

LATITUDE WELLNESS AND PREVENTION

LATITUDE WELLNESS AND PREVENTION

The State of South Dakota offers Latitude, a free wellness and prevention program, to all Members regardless of Health Plan.

Health is a deeply personal issue and not easily shared with an employer or even a health plan advocate, but positive lifestyle or attitude changes are an important part of good health. Health Management Partners (HMP) is working with the State to provide Latitude Wellness Programs.

As an employer, our responsibilities include:

- Offering wellness and prevention programs
- Engaging employees
- Personalizing wellness program options
- Supporting behavior changes

As an employee, your responsibilities include:

- Participating in Latitude Programs
- Setting personal goals
- Improving healthy behaviors

South Dakota State Employee Health Plan Members who may enroll in Latitude programs include:

- Employees
- Covered spouses of Employees
- Retirees and their covered spouses under the age of 65
- COBRA members and their covered spouses
- Dependent Children (Asthma and Diabetes Condition Management only)

Join us in taking the little steps that can make a big difference in your life and in your benefits.

HEALTH SCREENINGS

Completing a Health Screening is one requirement of the lowest deductible plan in FY15 which must be completed during FY14. The Health Screening is a face to face appointment to assess your biometric measurements. Health Screenings are scheduled from July 1 to December 31, in various locations across the state.

To Register for a Health Screening:

- Go to <http://latitude.hmpsd.com>
- Enter your DAKOTACARE ID # (9 digits) + the two digit number before your name (written as 01, 02, etc.) in the user name box.
- Enter your birth date (YYYYMMDD) in the password box.
- Choose your location, appointment date, and time.

Your Health Screening includes:

- Cholesterol (Total, HDL, LDL, Triglycerides, TC/HDL Ratio)
- Blood Pressure
- HbA1C
- Body Mass Index

The annual Health Screenings are offered to Members at no charge. You may locate more program information by visiting <http://benefits.sd.gov>, clicking Active or Retiree/COBRA, scrolling over Latitude, and clicking Health Screening.

LATITUDE PROGRAMS

Participating in a Latitude Program is one requirement of the lowest deductible plan in FY15 which must be completed during FY14. Detailed information about Latitude Programs will be available in Fall of FY14.

HEALTH ASSESSMENT

Completing a Health Assessment is one requirement of the lowest deductible plan in FY15 which must be completed during FY14. The online Health Assessment is available between January 1 to March 31.

The Health Assessment is confidential and takes about 15 minutes to complete.

To complete the Health Assessment:

- Go to <http://latitude.hmpsd.com>.
- Enter your DAKOTACARE ID # (9 digits) + the two digit number before your name (written as 01, 02, etc.) in the user name box.
- Enter your birth date (YYYYMMDD) in the password box.

Based on your responses, you receive a personalized report of your current health with tips on how to prevent or reduce your individual health risks for diabetes, cardiovascular disease, and other conditions.

CONDITION MANAGEMENT

Five programs are available to Members with chronic health conditions.

- **Asthma**
- **Pain**
- **Diabetes**
- **Cardiovascular**
- **Kidney Care**

Asthma Condition Management Program

The Asthma program is designed to prevent hospital admissions by promoting self-management skills and adherence to treatment guidelines. This program has four focus areas including:

- Education to enhance understanding and compliance
- Benefits of exercise
- Symptom Management
- Tobacco cessation

Respiratory Therapists will provide coaching for members in the following areas:

- Medication comprehension and compliance
- Symptom management to prevent exacerbations
- Proper use and maintenance of respiratory equipment
- Identify early warning signs and develop action plan
- Reinforce and practice breathing exercises and improve exercise tolerance
- Identify triggers and develop coping strategies
- Break away from tobacco dependency with one-on-one support

The Asthma program is offered via telephonic coaching and education materials (mailed and online). Members who opt to participate in telephonic coaching are considered “engaged” members and receive additional program incentives.

Program Incentives:

As an engaged member, your program incentives are determined by your risk stratification level.

Stratification Levels:

High Risk: Level 3

- 2 Telephonic coaching calls per month
- 1 “Asthma only” office visit per plan year
- Educational Material available when appropriate
- 1 Replacement spacer per plan year for better concentration of the medication and administration
- 1 Peak Flow Meter per member for self-monitoring of the asthmatic condition

Medium Risk: Level 2

- 1 telephonic coaching call per month
- 1 “Asthma only” office visit per plan year
- Educational Material available when appropriate

- 1 Replacement spacer per plan year for better concentration of the medication and administration
- 1 Peak Flow Meter per member for self-monitoring of the asthmatic condition

Low Risk: Level 1

- 4 telephonic coaching calls per year
- 1 “asthma only” office visit per plan year
- Educational Material available when appropriate
- 1 Replacement spacer per plan year for better concentration of the medication and administration
- 1 Peak Flow Meter per member for self-monitoring of the asthmatic condition

Very Low Risk: Level 0

- 1 telephonic coaching call per year
- Educational Material available when appropriate

Stratification:

Members are stratified based on the results of a complete assessment of their health, which involves determining the clinical risk of the member with their diagnosis (either primary or co-morbidities), their health literacy or knowledge of their diagnosis/condition, and their readiness to change. The stratification level may change as member needs and clinical status changes.

Program Incentives CPT Codes:

The following will be paid at 100% when provided by an in-network provider:

- Asthma only office visit. Office visit must have one of the following-CPT codes:
 - 99201-99205
 - 99211-99215
 - 99241-99245
 - 99381-99404
- The diagnosis code below must be used.
 - 496
 - 493.XX
 - V82.9

Additional Condition Management information is available at the following website addresses:

Members

<http://benefits.sd.gov>, click Active Employee, scroll over Latitude, and click Condition Management.

Providers

<http://benefits.sd.gov>, click Active Employee, scroll over Latitude, and click Condition Management.

Contact Information:

Call 877.573.7347, option 3 for Health Management Partners, and then option 4 for Condition Management.

Pain Condition Management

The Pain program is designed to promote recovery from chronic pain and prevent future chronic pain issues. This program focuses on following areas:

- Symptom specific education
- Proper instruction for endurance, strength, and flexibility
- Assessment and optimization of body mechanics and posture
- Alternative measures

A health coach will provide coaching for members in the following areas:

- Injury/re-injury prevention education
- Appropriate pain management strategies
- Personalized stretching and strengthening plans
- Reinforcement of therapy goals and instructions
- Goal-setting and recovery planning
- Stress management and relaxation techniques
- Medication review
- Review of occupational workstation ergonomics

The Pain program is offered via telephonic coaching and education materials (mailed and online). Members who opt to participate in telephonic coaching are considered “engaged” members and receive additional program incentives.

Program Incentives:

As an engaged member, your program incentives are determined by your risk stratification level.

High Risk: Level 3

- Two telephonic coaching calls per month
- One office visit per plan year with a pain specialist
- Up to 2 Physical Therapy visits per plan year to promote a home program compliance
- Educational material available when appropriate

Medium Risk: Level 2

- Monthly telephonic coaching calls per month
- One office visit per plan year with a pain specialist
- Up to 2 Physical Therapy visits per plan year to promote a home program compliance
- Educational material available when appropriate

Low Risk: Level 1

- Four telephonic coaching calls per year
- Up to 2 Physical Therapy visits per plan year to promote a home program compliance
- Educational material available when appropriate

Very Low Risk: Level 0

- One telephonic coaching call per year
- Educational material available when appropriate

Stratification:

Members are stratified based on the results of a complete assessment of their health, which involves determining the clinical risk of the member with their diagnosis (either primary or co-morbidities), their health literacy or knowledge of their diagnosis/condition, and their readiness to change. The stratification level may change as member needs and clinical status changes.

Program Incentive CPT Codes:

The Pain Management program is specific to the condition the member presents. Due to the varied nature of the conditions that may fall under this program, the member's Health Coach, in collaboration with the HMP Clinical Management will determine the medical appropriateness of a Certified Pain Specialist appointment. This will be based upon the member's presented condition or diagnosis. The Health Coach will assist in coordinating and completing the pre-authorization prior to the Pain Specialists and/or Physical Therapy appointments.

Preauthorization of the services will be required. Incentives include:

- 1 visit to a pain specialist, office visit CPT codes 99201-99215 will be considered eligible for benefit. Any additional services such as x-ray, scans, lab work will be considered under the provisions of the member's health plan at their regular plan benefits.
- Up to 2 Physical Therapy visits that will educate the member on home therapy programs, eligible CPT codes are:
 - 97110
 - 97535
 - 97530

Additional Condition Management information is available at the following website addresses:

Members

- <http://benefits.sd.gov>, click Active Employee, scroll over Latitude, and click Condition Management.

Providers

- <http://benefits.sd.gov>, click Active Employee, scroll over Latitude, and click Condition Management.

Contact Information

- Call 877.573.7347, option 3 for Health Management Partners, and then option 4 for Condition Management.

Diabetes Condition Management

The Diabetes Program is designed to improve self-management skills and promote adherence to treatment guidelines to reduce the risk of diabetes-related complications. This program has four focus areas including:

- Education to enhance understanding and compliance
- Benefits of exercise
- Nutrition counseling
- Tobacco cessation

A Health Coach will provide coaching for members in the following areas:

- Medication comprehension and compliance
- Optimizing physical activity levels to meet recommended guidelines
- Nutrition counseling for carbohydrate counting and weight management
- Blood pressure and cholesterol management
- Self blood glucose monitoring and recognizing signs of low and high blood glucose levels
- Break away from tobacco dependency with one-on-one support

The Diabetes program is offered via telephonic coaching and education materials (mailed and online). Members who opt to participate in telephonic coaching are considered “engaged” members and receive additional program incentives.

Program Incentives:

As an engaged member, your program incentives are determined by your risk stratification level.

High Risk: Level 3

- Two telephonic coaching calls per month
- Up to 3 office visits per plan year
- Up to 3 HbgA1C-per plan year
- Up to 2 Lipid profile per plan year
- Up to 3 Visits to a Registered Dietician per plan year
- 1 Urine for protein/creatinine
- 2 Comprehensive Metabolic Panels (includes a fasting blood sugar & Serum Creatinine) per plan year
- 1 Foot exam by medical doctor per plan year
- 1 Retinal exam per plan year
- Educational material available when appropriate

Medium Risk: Level 2

- 1 telephonic coaching call per month
- Up to 2 office visits per plan year
- Up to 2 HbgA1C per plan year
- Up to 2 Lipid profile per plan year
- Up to 2 Comprehensive Metabolic Panels (includes a fasting blood sugar & Serum Creatinine) per plan year
- Up to 2 Visits to a Registered Dietician per plan year
- 1 Urine for protein/creatinine per plan year
- 1 Foot exam by medical doctor per plan year
- 1 Retinal exam per plan year
- Educational material available when appropriate

Low Risk: Level 1

- 4 telephonic coaching calls per year
- 1 office visit per plan year
- 1 HbgA1C per plan year
- 1 Lipid profile per plan year
- 1 Visit to a Registered Dietician per plan year
- 1 Comprehensive Metabolic Panel (includes fasting blood sugar & Serum Creatinine) per plan year

- 1 Urine for protein/creatinine per plan year
- 1 Foot exam by medical doctor per plan year
- 1 Retinal exam per plan year
- Educational material available when appropriate

Very Low Risk: Level 0

- 1 telephonic coaching call per year
- Educational material available when appropriate

Stratification:

Members are stratified based on the results of a complete assessment of their health, which involves determining the clinical risk of the member with their diagnosis (either primary or co-morbidities), their health literacy or knowledge of their diagnosis/condition, and their readiness to change. The stratification level may change as member needs and clinical status changes.

Program Incentive CPT Codes:

The following will be paid at 100% when provided by an in-network provider:

- Office visits (height, weight, and blood pressure required). Office visit must have one of the following-CPT codes:
 - 99201-99205
 - 99211-99215
 - 99241-99245
 - 99381-99404
- HbgA1C (glucose 3 month average)
 - CPT Code: 83036
- Lipid profile (cholesterol, HDL, LDL, and triglycerides)
 - CPT Codes: 80061 and/or 82465
- Comprehensive Metabolic Panel
 - CPT Codes: 80053
- Urine for protein/creatinine
 - CPT Codes: 84156 and/or 82570
- Annual retinal exam (by Physician or Optometrist)
 - CPT Codes: 92002 and/or 92004
 - 92014
 - 92012
 - 99211-99212
- One of the following diagnosis codes must be used:
 - 250.XX
 - 277.7
 - 790.21
 - 790.22
 - 790.29
 - V70.9
 - V77.1
 - V77.9

- V77.91
- V77.99
- V82.9

Additional Condition Management information is available at the following website addresses:

Members

<http://benefits.sd.gov>, click Active Employee, scroll over Latitude, and click Condition Management.

Providers

<http://benefits.sd.gov>, click Active Employee, scroll over Latitude, and click Condition Management.

Contact Information:

Call 877.573.7347, option 3 for Health Management Partners, and then option 4 for Condition Management.

Cardiovascular Condition Management

The Cardiovascular program is designed to improve self-management skills and promote adherence to treatment guidelines in order to reduce the risk of heart attacks and hospital admissions. This program has four focus areas including:

- Education to enhance understanding and compliance
- Benefits of exercise
- Nutrition counseling
- Tobacco cessation

A health coach will provide coaching for members in the following areas:

- Medication comprehension and compliance
- Fluid and sodium restrictions as recommended by the treating physician
- Optimizing physical activity levels to meet recommended guidelines
- Healthy nutrition and weight management counseling
- Blood pressure and cholesterol management
- Self-monitoring for signs and symptoms of a cardiac event
- Break away from tobacco dependency with one-on-one support

The Cardiovascular program is offered via telephonic coaching and education materials (mailed and online). Members who opt to participate in telephonic coaching are considered “engaged” members and receive additional program incentives.

Program Incentives:

As an engaged member, your program incentives are determined by your risk stratification level.

Stratification Levels:

High Risk: Level 3

- 2 telephonic coaching calls per month
- Up to 3 office visits per plan year
- Up to 2 Lipid profile per plan year
- 1 Urine for protein/creatinine per plan year
- Up to 2 Comprehensive Metabolic Panels (includes fasting blood sugar) per plan year

- Educational material available when appropriate

Medium Risk: Level 2

- 1 telephonic coaching call per month per plan year
- Up to 2 office visits per plan year
- Up to 2 Lipid profile per plan year
- Educational material available when appropriate
- Up to 2 Comprehensive Metabolic Panels (includes fasting blood sugar) per plan year
- 1 Urine for protein/creatinine per plan year

Low Risk: Level 1

- 4 telephonic coaching calls per year
- 1 office visit per plan year
- 1 Lipid profile per plan year
- 1 Comprehensive Metabolic Panel (includes fasting blood sugar) per plan year
- 1 Urine for protein/creatinine per plan year
- Educational material available when appropriate

Very Low Risk: Level 0

- 1 telephonic coaching call per year
- Educational material available when appropriate

Stratification:

Members are stratified based on the results of a complete assessment of their health, which involves determining the clinical risk of the member with their diagnosis (either primary or co-morbidities), their health literacy or knowledge of their diagnosis/condition, and their readiness to change. The stratification level may change as member needs and clinical status changes.

Program Incentive CPT Codes:

The following will be paid at 100% when provided by an in-network provider :

- Office visits (height, weight, and blood pressure required). Office visit must have one of the following CPT Codes:
 - 99201-99205
 - 99211-99215
 - 99241-99245
 - 99381-99404
- Lipid profile (cholesterol, HDL, LDL, and triglycerides)
 - CPT Codes: 80061 and/or 82465
- Comprehensive Metabolic Panel
 - CPT Code 80053
- Urine for protein/creatinine
 - CPT Codes: 84156, 82570
- One of the following diagnosis codes must be used:
 - 272.0-272.4
 - 401.XX-414.9
 - 796.2

- V70.9
- V71.7
- V77.91
- V81.0-V81.2
- V82.9

Additional Condition Management information is available at the following website addresses:

Members

- <http://benefits.sd.gov>, click Active Employee, scroll over Latitude, and click Condition Management.

Providers

- <http://benefits.sd.gov>, click Active Employee, scroll over Latitude, and click Condition Management.

Contact Information:

- Call 877.573.7347, option 3 for Health Management Partners, and then option 4 for Condition Management.

Kidney Care Condition Management

The Kidney Care Program is designed to improve self-management skills and promote adherence to treatment guidelines in order to reduce the risk of hospital admissions. This program has three focus areas including the following:

- Education to enhance understanding and compliance
- Nutrition counseling
- Tobacco cessation

A health coach will provide coaching for members in the following areas:

- Medication comprehension and compliance
- Fluid and sodium restrictions as recommended by the treating physician
- Healthy nutrition and weight management counseling
- Blood pressure and cholesterol management
- Self monitoring
- Break away from tobacco dependency with one-on-one support

The Kidney Care Conditions Management Program is offered via telephonic coaching and educational material (mailed and online). Members who choose to participate in telephonic coaching are considered “engaged” members and receive additional program incentives. The Kidney Care Program is managed by a registered nurse with a background in nephrology. The Kidney Care Conditions Manager meets with a board certified nephrologists on a weekly basis to review new members, develop and review plans of care, and review incoming laboratory results. When necessary, HMP’s nephrologist will make contact with treating providers to ensure the highest level of quality care.

Program Incentives:

As an engaged member, your program incentives are determined by your risk stratification level.

Stratification Levels:

High Risk: Level 3

- 2 telephonic coaching calls per month

- Educational materials when appropriate
- Up to 2 Clinic appointments with a board certified nephrologist
- Up to 2 Comprehensive Metabolic Panel with *Glomerular Filtration Rate (GFR)*
- Up to 2 Hemoglobin and Hematocrit levels
- Up to 2 Parathyroid hormone levels
- Up to 2 Lipid Panels
- Up to 2 Phosphorous (serum) level
- Up to 2 urine for albumin and creatinine ratio or protein and creatinine ratio
- Up to 2 Urinalysis
- 1 Ultrasound within 2 years of both kidneys, bladder, aorta and blood flow to the kidneys

Medium Risk: Level 2

- 1 telephonic coaching call per month
- Educational materials when appropriate
- 2 Up to Clinic appointments with a board certified nephrologist
- Up to 2 Comprehensive Metabolic Panel with *Glomerular Filtration Rate (GFR)*
- Up to 2 Hemoglobin and Hematocrit levels
- Up to 2 Parathyroid hormone levels
- Up to 2 Lipid Panels
- Up to 2 Phosphorous (serum) level
- Up to 2 Urinalysis
- Up to 2 Urines for albumin and creatinine ratio or protein and creatinine ratio
- Up to 1 Ultrasound within 2 years of both kidneys, bladder, aorta and blood flow to the kidneys

Low Risk: Level 1

- 4 telephonic coaching calls per year
- Educational materials when appropriate
- Up to 1 Clinic appointment with a board certified nephrologist
- Up to 1 Comprehensive Metabolic Panel with *Glomerular Filtration Rate (GFR)*
- Up to 1 Hemoglobin and Hematocrit level
- Up to 1 Urinalysis
- Up to 1 Urine for albumin and creatinine ratio or protein and creatinine ratio

Very Low Risk: Level 0

- 1 telephonic coaching call per year
- Educational materials available when appropriate

Stratification:

Members are stratified based on the results of a complete assessment of their health, which involves determining the clinical risk of the member with their diagnosis (either primary or co-morbidities), knowledge of their diagnosis or condition, and readiness to change. The stratification level may change as member needs and clinical status changes.

Program Incentive CPT Codes:

The following will be paid at 100% when provided by an in-network provider per plan year:
Nephrologist offices visit with blood pressure. Office visit must have one of the following-

- 99201-99205

- 99211-99215
- 99241-99245

Hemoglobin & Hematocrit

- 85018 or 85014

Comprehensive Metabolic Panel with GFR

- 80053 and 82565

Urine for albumin/creatinine ratio or protein/creatinine ratio

- 82570 and 82043 or 82570 and 84156

Urinalysis

- 81001

Parathyroid hormone

- 83970

Phosphorous - (serum)

- 84100

Lipid Panel

- 80061 or 83721 or 82465

Ultrasound within 2 years both kidneys, bladder, aorta, and blood flow to the kidneys for Kidney Care disease

- 76770 or 76775

The diagnosis code below must be used.

- 585.xxx
- 584.xxx
- 403.xxx
- 404.xxx

Additional Condition Management information is available at the following website addresses:

Members

- <http://benefits.sd.gov>, click Active Employee, scroll over Latitude, and click Condition Management.

Providers

- <http://benefits.sd.gov>, click Active Employee, scroll over Latitude, and click Condition Management.

Contact Information

- Call 877.573.7347, option 3 for Health Management Partners, and then option 4 for Condition Management

ELIGIBLE PREVENTIVE CARE

The Plan covers:

- Cancer Screening Procedures
- Maternity Care
- Our Healthy Baby
- Well Child Care
- Scheduled Immunizations and Vaccinations

CANCER SCREENING PROCEDURES

The preventive cancer screening benefits pay 100% when the Member meets age and frequency requirements and utilizes a participating provider. Procedures are eligible for preventive benefit prior to satisfying Deductible.

Preventive Cancer Screening Procedure Coverage Under all Three Health Plans		
Procedure	Frequency	Plan Pays
Routine Pap Smear and Thin Prep Screening, HPV (human papillomavirus) screening, Chlamydia screening	1 per Plan Year	<ul style="list-style-type: none"> • Office Visit • Cost of Procedure • Ancillary Fees • Biopsies Fees • Lab Fees • Pathology Fees • Physician Services • Reading/Interpretive Fees • Testing Fees
Mammogram and Digital Mammograms	1 baseline between ages 35-39 1 per Plan Year beginning at age 40	
Sigmoidoscopy	1 every 5 Plan Years beginning at age 50	
Colonoscopy	1 every 10 Plan Years beginning at age 50 for Members with no risk factors	
	1 every 3 Plan Years beginning at age 50 for Members with colorectal cancer risk factors	
Prostate Screening	1 per Plan Year beginning at age 50	

Sources: American Cancer Society, American Medical Association, and Center for Medicare and Medicaid Services

When a covered Dependent attends school out-of-state, or when the Member resides out-of-state, Preventive Care services as listed are covered per this section. In this situation, any charges above Usual, Customary, and Reasonable (UCR) are the Member’s responsibility to pay, unless services are provided by a PHCS provider.

If a medical diagnosis is present and a preventive benefit is available, the preventive benefit will apply. If additional tests are ordered by a physician and medically necessary, they will be paid at normal plan benefits.

Tests outside of the cancer screening are not covered by the preventive cancer screening benefit.

MATERNITY CARE

Maternity Care services include obstetrical care for a routine 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), vaginal delivery and postpartum care, lab charges and other ancillary services associated with Office Visits..

After the Deductible is satisfied, 75% of eligible expenses are paid by the Plan. This could include Physician visits, vaginal delivery, postpartum care, and lab charges. Additional covered benefits for expectant mothers who enroll in Our Healthy Baby program.

\$500 DEDUCTIBLE PLAN

Member Responsibility:

- Deductible-\$500
- Coinsurance-25% of eligible charges
- Out-of-Pocket Maximum of \$2,500 per person if in network, \$5,000 if out-of-network

Under the \$500 Deductible Plan, if the mother (Plan Member) and the child are released from the Hospital:

- together, the Deductible and Coinsurance apply for the mother only
- separately, both the mother and child have a Deductible and Coinsurance

\$1,000 DEDUCTIBLE PLAN.

Member Responsibility:

- Deductible-\$1,000
- Coinsurance-25% eligible charges
- Out-of-Pocket Maximum of \$3,500 per person if in network, \$5,000 if out-of-network

Under the \$1,000 Deductible if the mother (Plan Member) and the child are released from the Hospital:

- together, the Deductible and Coinsurance apply for the mother only
- separately, both the mother and child have a Deductible and Coinsurance

\$1,800 DEDUCTIBLE PLAN

Member Responsibility:

- Deductible-\$1,800 Single or \$3,600 Family
- 25% of eligible charges
- Out-of-Pocket Maximum of \$3,600 for single in network coverage, \$7,200 per family for in network coverage; \$5,400 for single out of network coverage and \$10,800 per family for out-of-network coverage.

Under the \$1,800 Deductible Plan, if the mother (Plan Member) and the child are released from the hospital:

- together, the Deductible applies for the mother only
- separately, mother and child have the Family Deductible

Charges in connection with the Pregnancy of a Dependent child are not covered.

OUR HEALTHY BABY PROGRAM

The Our Healthy Baby™ Program is a voluntary program available to expectant mothers covered by the South Dakota State Employee Health Plan.

The purpose of this program is to provide support to expectant parents through individual case management, educational materials, and contact throughout the Pregnancy. By providing this service, the South Dakota State Employee Health Plan achieves healthier outcomes for Members.

Program incentives include:

- Expectant mothers covered under the Plan who enroll in the program within the first three months of Pregnancy receive a **\$250 non-tax incentive** into their Health Reward and Wellness Account;
- Choice of one available prenatal or parenting book upon enrollment;
- One first trimester ultrasound to confirm viable pregnancy covered at 100% (Pre-authorized by HMP);
- One second trimester ultrasound to verify dates and growth covered at 100% (Pre-authorized by HMP);
- Online access to Pregnancy related information;
- Educational materials mailed to Members throughout the Pregnancy;
- Expectant mothers covered under the Plan who complete the program receive an additional **\$250 non-tax incentive** into their Health Reward and Wellness Account upon successful participation and completion of program; and
- Follow-up after the Pregnancy.

Enrollment in the Our Healthy Baby™ Program does not automatically add the new child to the Health Plan.

To be covered, the child must be enrolled in the Plan within 60 days of the birth. The Employee must complete a Family Status Change form during the 60 day time period and pay required contributions for coverage to take effect.

If the child is not added during the 60-day Special Enrollment Period, the child will not be covered under the Plan. The Employee will be able to enroll the child during Annual Enrollment or when incurring qualifying family status change or after satisfying a waiting period. See “Special Enrollment” and “Late Entrants to the South Dakota State Employee Health Plan” sections.

Expectant Dependents are not eligible for maternity benefits under the South Dakota State Employee Health Plan.

For more information contact Health Management Partners (HMP), at 1.888.821.2242 or by enrolling online at <http://latitude.hmpsd.com>. Log in to the portal then choose Our Healthy Baby under Programs.

WELL CHILD CARE

To be covered under the Plans, Preventive Care services must be received from a participating provider.

When a covered Dependent attends school out-of-state, or when the Member resides out-of-state, Preventive Care services as listed are covered per this section. If Member utilizes a non PHCS provider, any charges above Usual, Customary, and Reasonable (UCR) are the Member's responsibility to pay.

All three health plans cover well child care at 100% through age 6, including Office Visits, lab work, and immunizations, according to the schedule when services are provided by a participating provider.

Age	Frequency
Birth to 12 Months	5 exams <ul style="list-style-type: none">• 1 exam between birth and 2 months• 1 exam at 2, 4, 6, and 9 months
Age 1 to 2 nd Birthday	3 exams
2 through 6 years	1 exam per Plan Year
7+ years	No Coverage

SCHEDULED IMMUNIZATIONS AND VACCINATIONS

Scheduled immunizations and vaccinations are available under all health three plans.

When a covered Dependent attends school out-of-state, or when the Member resides out-of-state, Preventive Care services as listed are covered per this section. Member utilizes a non PHCS provider, any charges above Usual, Customary, and Reasonable (UCR) are the Member’s responsibility to pay.

The following immunizations are:

- covered at 100% when services are provided by a participating provider.
- not covered when services are provided by a non-participating provider.

Treatment	Frequency
Hepatitis A Vaccine	At 12-24 months
Hepatitis B Vaccine	At birth, plus 2 between birth and 18 months
Rotavirus	At 2, 4, and 6 months
DTaP Vaccine	At 2, 4, 6, and 15-18 months
DTaP Booster	Once between 4 and 6 years
IPV Vaccine	At 2, 4, and 6-18 months
IPV Booster	Once between 4 and 6 years
MMR Vaccine	At 12-15 months and 1 dose 4-6 years
HIB Vaccine	At 2, 4, and 6 months plus 1 booster at 12-15 months
Varicella Vaccine	At 12-15 months and 1 dose between 4 and 6 years; 2 doses for adults 19-65 years
Pneumococcal Conjugate Vaccine (PCV or Prevnar) a vaccine to prevent pneumonia	At 2, 4, 6, and 15-18 months
Pneumovax	Allowed with documented risk factors for ages 19 to 65 years
Tdap	Once at 11-12 years of age, and every 10 years for adults
Tetanus/Diphtheria Booster	Every 10 years for adults
HPV	11-26 years, 3 dose series
Meningitis, Meningococcal Conjugate Vaccine	Age 11-12, and 1 booster at age 16.
Influenza Vaccine	1 to 2 doses between age 6 months through age 6, and once each Plan Year thereafter at a State sponsored clinic. <ul style="list-style-type: none"> • High Risk Members are eligible to have an influenza vaccine covered through the health plan at the preventive benefit. High risk may include those with sickle cell disease, human immunodeficiency virus (HIV) infection, and others who are immunocompromised or have a chronic medical condition. • All other plan members should receive the influenza vaccine FREE at a State sponsored clinic. Check http://benefits.sd.gov/ for times and locations.
Zoster (Shingle)	1 dose for adults age 60 and older

Sources: Department of Health and Human Services, Center for Disease Control and Prevention, and South Dakota Department of Health.

- If a combination vaccine is received, the Member must be eligible to receive at least one of the vaccines included in the combination vaccine to be covered.
- Vaccinations required for employment are not eligible.

LATITUDE EMPLOYEE ASSISTANCE PROGRAM (LEAP)

LEAP helps employees resolve a wide range of issues and restore both personal and professional effectiveness. LEAP will assist employees in managing the personal challenges that influence well-being, performance, and effectiveness. Employees using LEAP services must follow established leave policies; contact your Human Resource Manager with questions.

LEAP Eligibility

(LEAP) is available to benefit eligible state employees and Dependents. State employees and Dependents do not need to be covered under the South Dakota State Employee Health Plan to use LEAP services. Visit www.apsheplink.com and enter company code southdakota to learn more or call 800.713.6288.

Covered Services:

- Stress/Anxiety
- Financial/Legal Concerns
- Managing Change & Transition
- Drug/Alcohol
- Work Related Concerns
- Family/Relationship Issues
- Grief
- Depression
- Parenting Issues
- Child/Eldercare Issues
- Management or Supervisory Issues

Program Incentives:

- Telephonic support by Masters and PhD level counselors for crises and emergencies
- Telephonic support to arrange for in-person counseling
- Up to 5 in-person counseling sessions (per incident per fiscal year) for a range of personal issues, depression, work-family balance, and substance abuse concerns. Employees must have a referral from APS to use counseling services.

Consultation Services:

In addition, LEAP offers consultations including:

- **Family Caregiving** - Resources and referrals for dependent care related services, in addition to emergency back-up childcare and elder and more.
- **Convenience Services** - Assistance in locating household and daily living resources, including pet care services, home repairs, travel planning and event scheduling and more.
- **Financial Services** - Up to 30-minutes financial consultation with a Certified Financial Planner or CPA per issue at no-cost.
- **Legal Services** - Up to 30-minutes consultation per issue with an attorney at no-cost and 25% discount of fees if you decide to retain an attorney

VERIFICATION OF TOBACCO USER STATUS

IDENTIFICATION OF TOBACCO USER STATUS

As part of the enrollment process, new Employees must indicate whether they and/or their covered spouse use tobacco. Employee and Dependent contributions for Health Coverage during the Plan Year will be based on the Employee's response to the tobacco use question.

This election is required even if the Employee is not making any other benefit choices.

CHANGES TO TOBACCO USER

If an Employee and/or the covered spouse change from being non-tobacco users to tobacco users during the Plan Year, the Employee must complete a "Tobacco Use Election Form" (available at <http://benefits.sd.gov> or Human Resources) to indicate the change in usage.

If a spouse is added to the Health Plan during the Plan Year, the Employee must provide all required information about the spouse's tobacco user status. (See the chart on next page for details about the effect of the tobacco user contribution rate.)

CHANGES TO NON-TOBACCO USER

If an Employee and/or the covered spouse change from being a tobacco user to a non-tobacco user during the Plan Year, one of the following is required:

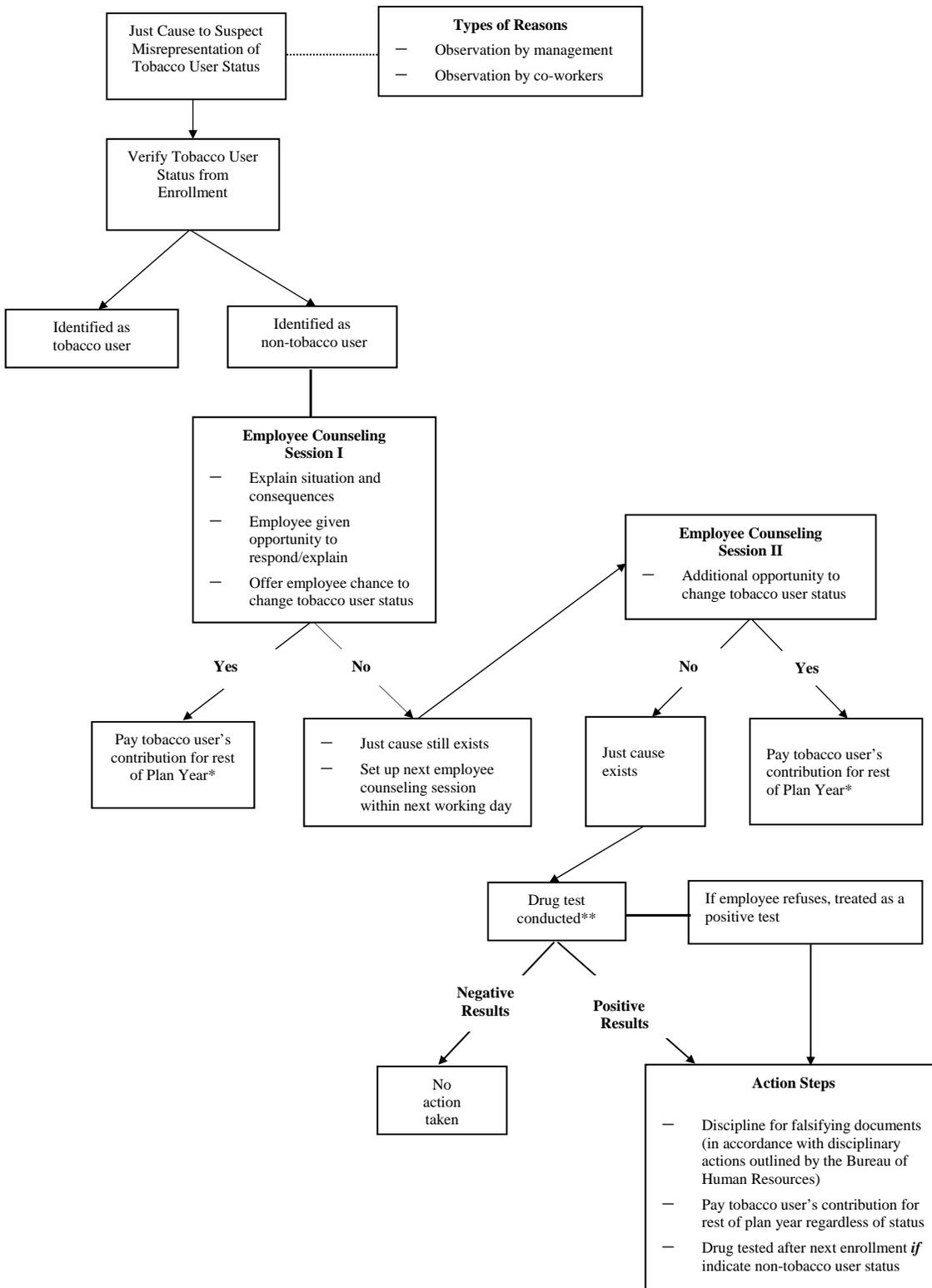
- 1) The Employee must change the tobacco user election by logging on to the Internet Enrollment System during Annual Enrollment,
- 2) Employee or spouse successfully complete the South Dakota Department of Health tobacco QuitLine (1-866-SDQUITS or 1-866-737-8487) and submit a copy of the QuitLine certificate of completion to the Bureau of Human Resources, or
- 3) Employee submits written documentation to the Bureau of Human Resources stating the employee or spouse have been tobacco-free for a minimum of 120 days.

VERIFICATION OF TOBACCO USER STATUS

The State reserves the right to verify an Employee's tobacco user status during the Plan Year, and the Employee could face disciplinary action and/or the reduction of health and life benefits if tobacco use is misrepresented.

The following flowchart shows the process when, if reasonable or just cause indicates an Employee has misrepresented tobacco use. Just or reasonable cause may include, but is not limited to, reported observations of tobacco use by a co-worker or management staff.

The following non-tobacco incentive policies are in line with the overall movement by the State toward wellness, prevention, and managed care. According to the Centers for Disease Control and Prevention, cigarette smoking is the leading preventable cause of death in the United States. Employees and covered spouses using tobacco are encouraged to contact SD Quits at 1.866.737.8487 or www.befreesd.com/quitline.html for more information.



* Employee may re-enroll the following Plan year as a non-tobacco user, without proof of tobacco user status.

** The drug test to determine if an Employee is currently using tobacco will be administered through a certified testing laboratory. The cost of administering the test will be paid by the State.

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.

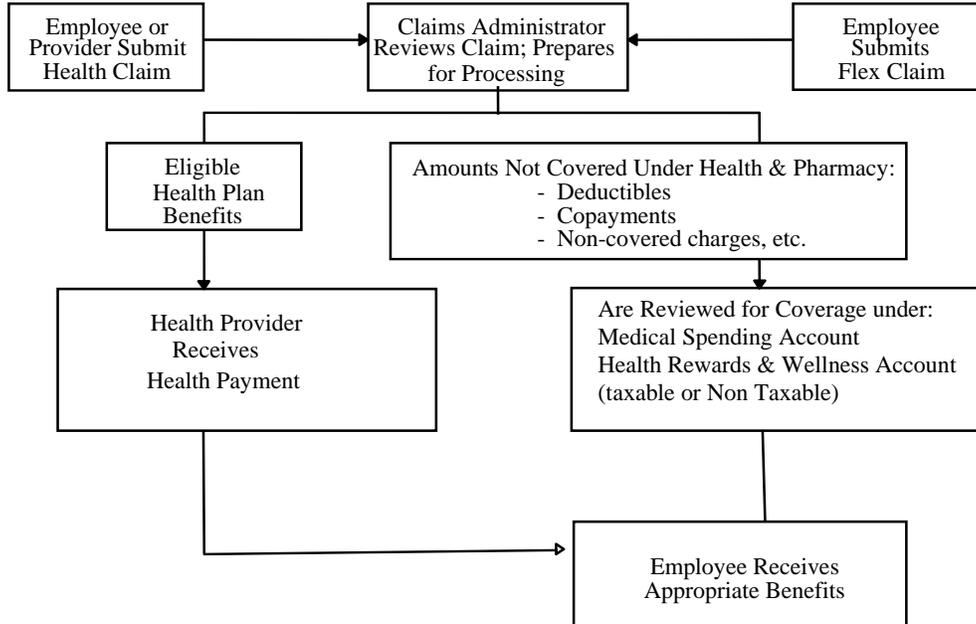
Approval for processing must be obtained from the Bureau of Human Resources. Upon completion, members should receive an Explanation of Benefits (EOB).

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 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 has 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.

WHEN COVERAGE ENDS AND CONTINUATION OF COVERAGE

An Employee's coverage under the Health Plan ends on the earliest of:

- (a) Last day of the coverage period following the date employment ends, as set forth in (b) below;
- (b) Date the Employee ceases to be a Member of the class or classes eligible for such coverage;
- (c) End of the period covered by the Employee's last contribution for that coverage;
- (d) Last day of the coverage period following the date the Employee begins active duty in the armed forces; or
- (e) Date the Plan terminates.

Dependent coverage ends on the earliest of these dates:

- (a) Date the Employee's coverage under the Plan ends;
- (b) Last day of the coverage period in which the Dependent ceases to qualify as a Dependent;
- (c) End of the period covered by the Employee's last contribution for that coverage;
- (d) Last day of the coverage period following the date the Dependent begins active duty in the armed forces of any state;
- (e) Date the Employee becomes ineligible to have Dependents covered under that Plan; or
- (f) Date the Plan terminates.

Employment for coverage purposes ends on the date the Employee ceases active work or benefit eligible status changes with the Employer. The ending date of Health Coverage will be based on the pay period for which the Employee receives his or her final paycheck. Employees should contact their Human Resource/Personnel Office for specific information.

APPROVED LEAVE OF ABSENCE WITHOUT PAY

An approved leave of absence without pay is not treated as a termination of employment. An approved leave of absence without pay includes an absence due to Injury, disease, Pregnancy, or an absence pursuant to the Family Medical Leave Act (FMLA) of 1993. Benefits under the South Dakota State Employee Health Plan may continue provided the Employee continues to make after-tax contributions to the Plan according to the billing process established by the Bureau of Human Resources or the Board of Regents. If Employee terminates employment, then coverage will end prior to the actual termination date and Retiree and COBRA continuation of coverage will not be available.

Coverage during a period of absence will end if the Employee does not pay the required contributions. For example, if the Employee goes on leave of absence without pay from January 1 until March 1, and

does not pay the contributions for coverage, the Employee will have a break in coverage. Coverage will also end if the authorized period of absence ends and the Employee does not return to work, or when the Plan Administrator otherwise determines that employment has terminated. Retiree and COBRA continuation of coverage will not apply.

NOTE: If an Employee terminates employment and is rehired during the same Plan Year, coverages elected during the previous period of employment, and in effect at the time of termination, will be reactivated with no changes.

If the Employee does not make required contributions as billed for health insurance while on a leave without pay status, Dependent Health Coverage will end. See “Late Entrants to the South Dakota State Employee Health Plan”.

If leave without pay contributions are not paid and the Employee terminates employment, then coverage will end prior to the actual termination date and Retiree and COBRA continuation of coverage will not be available.

RETIREE COVERAGE (COBRA)

Eligible retired Members may continue group Health Coverage as a Retiree Member up to the first day of the month in which they reach age 65, at which time coverage may be converted to the State-sponsored Medicare Supplement Plan.

Eligible Members who are receiving a Disability benefit from the South Dakota Retirement System (SDRS), or who have been designated as disabled by the Social Security Administration, may continue COBRA coverage for up to 29 months. There is no COBRA continuation of coverage if the Member is a Medicare recipient.

COBRA continuation coverage will end if a Member is approved for Medicare after his or her COBRA effective date.

Covered Dependents can remain on the Plan for as long as they remain qualified Dependents.

OPTION TO CONTINUE COVERAGE (COBRA)

An Employee and the Employee's eligible Dependents covered by the South Dakota State Employee Health Plan have the right to elect continuation coverage if coverage is lost because of one of the following qualifying events:

QUALIFY EVENT		LENGTH OF CONTINUATION COVERAGE
1)	Employee's Termination (for reasons other than gross misconduct)	Coverage for former Employee and eligible Dependents may be extended up to 18 months; up to 29 months if the Employee or an eligible Dependent is disabled prior to or within 60 days following the date of the qualifying event.
2)	Employee's Death	Coverage may be extended up to 36 months for eligible Dependents.
3)	Reduction of Employee's Hours	Coverage for the Employee and eligible Dependents may be extended up to 18 months; up to 29 months if the Employee or the eligible Dependent is disabled prior to or within 60 days following the date of the event.
4)	Divorce or Legal Separation	Coverage may be extended up to 36 months for qualified beneficiaries.
5)	Employee's Entitlement to Medicare	If an Employee becomes entitled to Medicare while an active Employee and within 18 months of that entitlement experiences a layoff, a termination of employment, or a qualifying reduction of his or her hours, qualified beneficiaries may extend coverage up to 36 months from the date the Employee became entitled to Medicare.
6)	Child Ineligible to be Covered as a Dependent	Coverage may be extended up to 36 months for the eligible Dependent.

The Employee or a family member has the responsibility to notify the Employee's Human Resource Office of a divorce, legal separation, Medicare entitlement or enrollment, or a child losing Dependent status under the South Dakota State Employee Health Plan. This notification must occur within 90 days of the date of the event or the date on which coverage would be lost due to the event, whichever is later. See "When Coverage Ends".

ELECTING CONTINUATION COVERAGE (COBRA)

For purposes of this Section, a qualified individual/beneficiary includes the Employee and any eligible Dependent of the Employee who is covered by the Plan on the date of the qualifying event. Employees and Dependents of an Employee who opts out of coverage under this Plan are not eligible for and may not elect continuation coverage pursuant to this section of the Plan.

The Employer is responsible for notifying the Employee and/or eligible Dependents of the right to elect continuation coverage in the case of the Employee's death, termination of employment, or reduction in hours of employment. The Employee and/or eligible Dependent has 60 days from the date coverage would end to elect continuation coverage. If the Employee and/or eligible Dependent does not elect continuation coverage, group Health Coverage under the Plan will cease.

If the Employee and/or eligible Dependent elects continuation coverage, the Employee and/or Dependent may elect a plan with less coverage (e.g. When an active Employee, the plan choice was the \$500 Deductible Plan. As a COBRA Member, the Member may elect the \$1,000 Deductible Plan or the \$1,800 Deductible Plan.)

The length of the continuation period will depend on the qualifying event. If an Employee or eligible Dependent is determined by Social Security to have been disabled prior to or within 60 days following the date of the qualifying event, he or she may obtain an extension of the COBRA continuation period from 18 months to 29 months (with proof of disability). Anyone electing continuation coverage may be charged 102% of the group rate charged for the same coverage.

If Medicare or another health plan is in effect prior to the COBRA effective date, the Employee and/or Dependent must be offered COBRA and may elect to participate in COBRA coverage as well as Medicare or another health plan, with COBRA as the secondary payer.

CONTINUATION COVERAGE ENDS

Continuation of coverage may be terminated or denied on the earliest date which may apply for any of the following reasons:

- (a) The Employee or covered Dependent acquires coverage under another group health, dental, or vision plan or any other plan*, and that plan does not limit or exclude coverage for Pre-existing medical conditions of the Employee or the Dependent age 19 or older;
- (b) The contribution for continuation coverage is not paid on time, including a grace period of 30 days after a payment due date or a period of 45 days following the day the qualified beneficiary initially elected continuation coverage;
- (c) The Employee or covered Dependent is entitled to or enrolled in Medicare or Medicaid after COBRA continuation coverage begins;
- (d) The State of South Dakota no longer provides group Health Coverage; or
- (e) The continuation period ends.

* Medicaid & TriCare or other Federal programs.

HEALTHCARE CERTIFICATIONS

If an Employee or an Employee's Dependent(s) lose coverage under the South Dakota State Employee Health Plan, the Plan Administrator will provide a Certificate of Prior Health Coverage. The purpose of the Certificate is to enable the Employee or Dependent to provide proof of prior health plan coverage to a subsequent health plan. Certificates will be provided automatically when the coverage ends under the Plan and when the COBRA coverage (if any) ends.

CONVERSION OF COVERAGE

The South Dakota State Employee Health Plan does not offer the opportunity to convert Health Coverage to an individual policy when COBRA continuation coverage ends.

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 Dependent. Formal cost containment agreements with providers may preclude sending benefit payments directly to Members or covered Dependents.

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.
- 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 and/or offset your future benefits 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.

COORDINATION OF BENEFITS (COB)

BENEFITS SUBJECT TO THIS PROVISION

All benefits under medical coverage in the Plan are subject to this provision.

There is no Coordination of Benefits between the Prescription Drug Plan and any other medical or prescription drug plan, previously or currently in place with a Plan Member.

End-stage renal disease pharmaceuticals prescribed for Medicare recipients (not including age 65+ retirees) will be coordinated with the South Dakota State Employee Health Plan. Claims for these pharmaceuticals should be submitted to DAKOTACARE using the Plan Claim Form.

If other valid and collectible insurance is available to an “insured” for a loss, covered by this Plan, it shall be primary, and the coverage under the South Dakota State Employee Health Plan shall be excess over any other insurance.

DEFINITIONS

As used in this provision:

- (a) **“Allowable Expense”** - Limited to those expenses that would be incurred by the Member through same or similar treatment at a provider or facility where the State has a direct contract for specific treatment.
- (b) **“Claim Period”** - A Plan Year. If a person is not covered under the South Dakota State Employee Health Plan for a full Plan year, the Claim Period for that year will be the part of the year during which the person was covered under the Plan.
- (c) **“Medical Coverage”** - Any coverage in the Plan providing benefits for any type of charge for which Medicare provides benefits.
- (d) **“Plan”** - A plan, insured or not, which provides benefits or services for medical, dental, or vision care through:
 - 1) group, individual or blanket coverage;
 - 2) group practice or other group prepayment coverage, including Hospital or medical services coverage;
 - 3) labor-management trusted plans;
 - 4) union welfare plans;

- 5) Plan Administrator organization Plans;
- 6) Employee benefit organization Plans;
- 7) coverage required or provided by law or government programs, except Medicaid. However, this coverage will not be considered a Plan, if covered expenses under the coverage are excluded from benefits under the South Dakota State Employee Health Plan.

The parts of a Plan, which coordinate benefits or services with other Plans, and the parts that do not coordinate benefits are considered separate Plans. For purposes of this Section, the term “Plan” refers only to those parts of a Plan, which provide benefits that are subject to this provision.

- (e) **“Primary to Medicare”** - Medicare is not considered for the purpose of the Coordination of Benefits provision. When a medical coverage is primary to Medicare, the benefits under that coverage are not coordinated with the ones that Medicare provides.
- (f) **“Senior Dependent”** - The spouse of an active Employee while:
 - 1) the spouse is age 65 or over and qualifies as a Dependent of the Employee; and
 - 2) the Employee’s Dependents are eligible under the Plan.
- (g) **“Senior Employee”** - Any active Employee age 65 or over who belongs to a class of employees eligible for medical coverage.

EFFECT ON BENEFITS

- (a) Coordination of Benefits apply to Allowable Expenses Incurred during any Claim Period by a covered Employee or Dependent, if the sum of the benefits payable for those Expenses under the two items below would exceed the Allowable Expense:
 - 1) This Plan in the absence of this provision; and
 - 2) All other Plans in the absence of similar provisions.
- (b) If Coordination of Benefits applies to a Claim Period, this Plan will reduce the benefits it would have otherwise paid for Allowable Expenses Incurred by the claimant during the Claim Period.

The reduction will be made to the extent needed. The sum of the reduced benefits and the benefits payable for Expenses under all other Plans coordinating benefits does not exceed the Allowable Expenses.

Benefits payable under another Plan include:

- 1) Those which would have been payable had a claim been duly made; and
- 2) In the case of Medicare coverage, all benefits, including Optional Benefits, whether or not the claimant is enrolled in these.

- (c) To determine benefits, this Plan will ignore another Plan if:
- 1) The other Plan which is coordinating its benefits with those of this Plan has a rule stating that it will determine its benefits after the benefits of this Plan have been determined; and
 - 2) The rules set forth in (d) below would require this Plan to determine its benefits before such other Plan.

(d) For the purpose of (c) above, here is the order in which this Plan determines benefits.

- 1) The benefits of the Plan which covers the person as an Employee, Member, subscriber or COBRA subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.
- 2) Except as stated in (3) below, when this Plan and another Plan both cover a Dependent child whose parents are separated or divorced:
 - (A) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; however
 - (B) If both parents have the same birthday, the benefits of the Plan, which covered the parent longer, are determined before those of the Plan, which covered the other parent for a shorter period of time.

If the other Plan has a rule based upon the gender of the parent instead of the rules described in (A) or (B) and if, as a result, the Plans do not agree on the order of benefits, the rules in the other Plan will determine the order of benefits.

- 3) If two or more Plans cover a person as a Dependent Child of divorced or separated parents, benefits for the child are determined in this order:
 - (A) first, the Plan of the parent with custody of the child;
 - (B) second, if the parent with custody has remarried, the Plan of the spouse of the parent with custody of the child; and
 - (C) finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for the healthcare expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Period or Plan Year during which any benefits are actually paid or provided before the entity has actual knowledge.

- 4) The benefits of the Plan which cover a person as an Employee who is actively at work (or a Dependent of such person) are determined before those of a Plan which cover the person as a laid off or Retired Employee (or a Dependent of such person). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, the rules in the other Plan will determine the order of benefits.
 - 5) If none of the above rules determines the order of benefits, the benefits of the Plan, which covered an Employee, Member, or subscriber longer, are determined before those of the Plan, which covered the person for the shorter time.
- (e) When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefits limit of this Plan.

MEDICAL COVERAGE FOR SENIOR EMPLOYEES

A person is deemed to be age 65 or over from the first day of the month in which the person attains age 65.

NOTE: Employees are not allowed to Opt-Out of the South Dakota State Employee Health Plan solely on the basis of Medicare and Medicaid eligibility. These programs are not considered valid group coverage for purposes of this provision.

A Senior Employee is eligible for the same medical coverage as younger Employees in the class to which the Senior Employee belongs.

Whether hired before or after age 65, Employees who enroll in the South Dakota State Employee Health Plan within 30 days of date of hire are covered for medical coverage one month and one day from date of hire.

While the Senior Employee remains covered for medical coverage, the Senior Employee's benefits under the coverage will be primary to Medicare. However, the Senior Employee will not remain covered for any medical coverage after the earlier of the date the Senior Employee's benefits under that coverage would end if the Senior Employee was under age 65; or if the Employee terminates employment, the end of the period covered by the Senior Employee's last contribution for the coverage.

The ending date of Health Coverage will be based on the pay period for which the Employee received his or her final paycheck. Employees should contact their Human Resource Office for specific information.

MEDICAL COVERAGE FOR A SENIOR DEPENDENT

An Employee's Senior Dependent is eligible for the same medical coverage as younger Dependent spouses of Employees in the class to which the Employee belongs.

While the Employee's spouse (Senior Dependent) remains covered for medical coverage, the Employee spouse's (Senior Dependent) benefits under the coverage will be primary to Medicare.

Medical coverage for the Employee's spouse will end as indicated below:

- (a) As the spouse of an Active Employee, medical coverage will end on the date the Employee terminates employment or benefits under that coverage would otherwise end.

- (b) As the spouse of a retiree, medical coverage under this Plan will end the first of the month in which the spouse turns age 65.

MEDICAL COVERAGE FOR RETIRED EMPLOYEES

Medicare is primary to the South Dakota State Employee Health Plan for Members and spouses who are retired. Medical coverage under the South Dakota State Employee Health Plan will end the first of the month in which the Member turns age 65. At that time, coverage may be converted to the State-sponsored Medicare Supplement Plan.

MEDICAL COVERAGE FOR CERTAIN EMPLOYEES AND DEPENDENTS

Whether this Plan is the primary payer of medical and pharmaceutical claims for an Employee or covered Dependent with end-stage renal disease depends on which occurs first: End-stage renal disease or attainment of age 65.

This Plan has secondary responsibility for the claims of a covered Member:

- (a) Who is eligible for Medicare benefits because of end-stage renal disease; but
- (b) Who first became eligible for Medicare Part A because of age or another disability.

This Plan has primary responsibility for the claims of a Member who is eligible for Medicare benefits solely because of end-stage renal disease, and then later also becomes eligible for Medicare benefits because of age or another disability.

PLAN ADMINISTRATION AND OPERATIONS

The South Dakota State Employee Health Plan is a “self-insured” Plan. The Bureau of Human Resources is the State agency responsible for designing and administering the Plan, including the administration and payment of claims. The Plan Administrator reserves the right to change the Plan design, modify coverage, and change contributions or funding mechanisms at any time it deems necessary, with or without notice. The Plan Administrator or other fiduciary designated by the Plan Sponsor shall have final authority to make a determination with respect to such issues or such provisions, unless such determination is found to be arbitrary and capricious by a court of appropriate jurisdiction. The information contained in this document and its interpretation by the Plan Administrator’s designee supersedes all verbal representations of the Plan provisions. The benefits paid are funded entirely by the contributions paid by the State and participating Employees.

The State of South Dakota pays the contribution for coverage for an Active Employee under the \$500 Deductible Plan, the \$1,000 Deductible Plan, or the \$1,800 Deductible Plan.

The Employee pays the contribution for Dependent coverage under the Plan.

The amount of such contribution will be established by the Bureau of Human Resources, at its sole discretion.

RIGHT TO RELEASE AND OBTAIN NECESSARY INFORMATION

The Plan Administrator may, without the consent of or notice to any person, release to or obtain from any other person or organization any information, which it deems needed to:

- (a) Determine if a Plan provision applies; and
- (b) Implement its terms or the terms of any provision of similar purpose of any other Plan.

Any claimant under this Plan shall furnish to the Plan Administrator the necessary information as may be needed to implement this provision.

FACILITY OF PAYMENT

If the payments, which should have been made by this Plan under the terms of this provision, are made under other Plans, the Plan Administrator may, at its discretion, pay to any person making such payment the amount it determines satisfies the intent of this provision. To the extent of the amount of those payments, the Plan Administrator shall be discharged from liability under this Plan.

RIGHT TO RECOVERY

If the Plan Administrator makes payments with respect to Allowable Expenses in a total amount, which is, at any time, in excess of the payment necessary at the time to satisfy the intent of this provision, it will have the right to recover such excess from:

- (a) Any persons to or for or with respect to whom such payments were made; and
- (b) Any organization, which should have made the payments.

ASSIGNMENT

The Plan Administrator retains the right to assign or to refuse assignment of benefits to providers.

PLAN MODIFICATION AND AMENDMENT

The State of South Dakota fully intends to continue the Plan or a similar Plan indefinitely. However, the Plan may be modified and amended at any time by the State of South Dakota or the Bureau of Human Resources upon its due approval of such modification or amendment. The modification or amendment shall be effective on the date of approval or on such date as the State of South Dakota may determine in connection therewith. Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan.

SEVERABILITY

If any portion of this Plan is subsequently found to be invalid by a court of law, the remaining provisions of the Plan will remain in effect.

PLAN TERMINATION

The State of South Dakota or the Bureau of Human Resources may terminate the Plan at any time as of the date it authorizes. In the event of such termination, the State of South Dakota shall have no obligation under the Plan beyond paying the difference between:

- (a) The claims Incurred (even though later filed) and expenses of the Plan due up to the date of termination plus extended benefits, if any, provided under the Plan; and
- (b) The funds available to pay such claims, expenses, and extended benefits.

Such claims and expenses shall be paid from the funds in the Plan. No benefits will be paid for expenses Incurred after the date the Plan ends.

The Bureau of Human Resources has the final and binding authority to determine claims and direct the payment thereof. The Bureau of Human Resources shall incur no liability for failure to make payment of any claim or to make ratable distribution on any claim without regard to the reasons therefore. The Bureau of Human Resources shall have the right to employ third party administrators (TPA) under the Plan to aid it in the discharge of its duties hereunder.

HIPAA PRIVACY AND SECURITY

This section describes the manner in which the Plan will protect certain health information used or maintained by the Plan.

The Company sponsors and maintains certain group health plans that are subject to the Health Insurance Portability and Accountability Act of 1996, (“HIPAA”) regulations as are described more fully in this Document. Under the privacy and security rules of HIPAA, and the regulations issued thereunder at 45 CFR Parts 160 and 164 (“the HIPAA regulations”), a group health plan must: (i) restrict the use and disclosure of protected health information (“PHI”), (ii) ensure the confidentiality, integrity, and availability of all electronic protected health information (“e-PHI”) the plan creates, receives, maintains, or transmits, (iii) protect against any reasonably anticipated threats or hazards to the security and integrity of such information, (iv) protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the HIPAA privacy rules set forth in 45 CFR Part 164, Subpart E, and (v) ensure compliance with the HIPAA security rules set forth in 45 CFR Part 164, Subpart C by its workforce;

1. **Uses and Disclosures of PHI.** The Plan and the Company may disclose a Plan Member’s PHI to the Company (or to the Company’s agent) for the Plan administration functions described under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations.
2. **Restriction on Plan Disclosure to the Company.** Neither the Plan nor any of its Business Associates, health insurance issuers, or HMOs, will disclose PHI to the Company except upon the Plan’s receipt of the Company certification that the Plan has been amended to incorporate the agreements of the Company under paragraph 3, except as otherwise permitted or required by law.
3. **Privacy Agreements of the Company.** As a condition for obtaining PHI from the Plan, its Business Associates, Insurers, and HMOs, the Company agrees it will:
 - a. Not use or further disclose such PHI other than as permitted by paragraph 1 of this section, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;
 - b. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Company with respect to such information;
 - c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Company;
 - d. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Company becomes aware;
 - e. Make the PHI of a particular Member available for purposes of the Member’s requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;
 - f. Make the PHI of a particular Member available for purposes of required accounting of disclosures by the Company pursuant to the Member’s request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

- g. Make the Company's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
- h. If feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Company agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- i. Ensure that there is adequate separation between the Plan and the Company by implementing the terms of subparagraphs (1) through (3), below:

(1) *Employees With Access to PHI*: The following Employees or other individuals under the control of the Company are the only individuals that may access PHI received from the Plan:

- Commissioner
- Director
- Legal Counsel
- Assistant Director
- Personnel Specialists
- Benefits Analyst
- Program Assistants
- Senior Secretary

(2) *Use Limited to Plan Administration*: The access to and use of PHI by the individuals described in (1), above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Company for the Plan.

(3) *Mechanism for Resolving Noncompliance*. If the Company or any other person(s) responsible for monitoring compliance determines that any person described in (1), above, has violated any of the restrictions of this section, then such individual shall be disciplined in accordance with the policies of the Company established for purposes of privacy compliance, up to and including dismissal from employment. The Company shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

4. **Security Agreements of the Company**. As a condition for obtaining e-PHI from the Plan, its Business Associates, Insurers, and HMOs, the Company agrees it will:

- a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;
- b. Ensure that the adequate separation between the Plan and the Company as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;
- c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;
- d. Report to the Plan any Security Incident of which it becomes aware. For purposes of this section, "Security Incident" shall mean successful unauthorized access to, use, disclosure, modification or

destruction of, or interference with, the e-PHI; and

- e. Upon request from the Plan, the Company agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Company.

5. **PHI not Subject to this Section**. Notwithstanding the foregoing, the terms of this section shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504 (f)(1)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations; provided however that paragraph 4 above shall apply if and only if e-PHI beyond enrollment, disenrollment, summary health information, and authorized disclosures is obtained by the Company, and the Company adopts the literal interpretation of 45 CFR 164.314(b)(1), which would apply paragraph 4 unless the only e-PHI obtained is enrollment, disenrollment, summary health information, or authorized disclosures.
6. **Definitions**. All capitalized terms within this section not otherwise defined by the provisions of this section shall have the meaning given them in the respective Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA.