

# **BLACK HILLS EDUCATIONAL HEALTHCARE BENEFIT PLAN**

**September 1, 2011**

**Black Hills Special Services Cooperative**  
Sturgis, South Dakota





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## SUMMARY PLAN DESCRIPTION

This booklet contains a general description of benefits available under the Plan and is written to help participants understand them. The details of coverage are limited to the terms and conditions specified in this document which is intended to serve as both the Summary Plan Description and plan document. This document will now be referred to as the Plan. Participants may examine the Plan or obtain copies of it at any time. It is on file with Black Hills Special Services Cooperative.

This Plan was established for the exclusive benefit of the employees of Black Hills Special Services Cooperative with the intention it will continue indefinitely. However, Black Hills Special Services Cooperative reserves the right to amend, modify or terminate this Plan at any time without prior notice to the Plan participants. Any amendment or modification will be in writing, effected through a written resolution signed by the Business Manager and will be binding. If this Plan is terminated, participants may not receive benefits for claims incurred on or after the effective date of termination.

In addition, this Plan may not discriminate against any participant based on: health status; medical condition (including both physical and mental illnesses); claims experience; receipt of health care; medical history; genetic information; medical evidence of good health (including participation in certain dangerous recreational activities and conditions arising out of acts of domestic violence); and disability as mandated by the Health Insurance Portability and Accountability Act of 1996.

Based on the factors described above, this Plan may not require any individual (as a condition of enrollment or continued enrollment under this Plan) to pay a premium or contribution which is greater than the premium or contribution paid by a similarly situated individual enrolled in this Plan. Nothing in the preceding sentence will be construed: (a) to restrict the amount that may be charged for coverage under this Plan; or (b) to prevent this Plan from establishing premium discounts or rebates or modifying otherwise applicable coinsurance amounts, co-pays or deductibles in return for adherence to programs of health promotion and disease prevention.

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## INTRODUCTION

This Plan is designed to cover a participant's various health care expenses. This is a self-funded Plan of benefits which provides coverage for the health care needs of each covered person as specified in the Schedule of Benefits.

It is important that each participant understands this Plan in order to use it effectively. Each participant is encouraged to take the time to read this booklet to gain a basic understanding of the benefits. The Schedule of Benefits provides a brief review of the allowable benefits. The "What Are Covered Expenses?" section provides greater detail regarding the participant's benefits. Specially designated sections outline care not covered by this Plan.

If the participant has any questions about this Plan of benefits, he/she may contact First Administrators, Inc.

Correspondence can be mailed to:

First Administrators, Inc.  
P.O. Box 8150  
Rapid City, SD 57709-8150

or

Nationwide ..... 1-800-381-4830  
Rapid City ..... 1-605-399-7309

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## GRANDFATHERED HEALTH PLAN DISCLOSURE

This group health plan believes this 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 that your 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 essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to

change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the U.S. Department of Health and Human Services at [www.healthreform.gov](http://www.healthreform.gov).

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## PPO INTRODUCTION

This Plan features a preferred provider organization. The preferred provider organization utilizes a network of hospitals and physicians who have contracted to offer their services at a discounted rate. A directory of these providers may be furnished to the employee, without charge. If a participant uses preferred providers, the Plan will pay a higher level of benefits.

The preferred provider network's goal is to contain spiraling health care costs through utilization management and to do this without sacrificing the comprehensive nature of the benefits provided. Participating physicians follow specific guidelines to eliminate unnecessary inpatient hospital stays by utilizing outpatient services when possible and applying the wise use of diagnostic testing when applicable.

Participants always have freedom of choice. The services of any covered provider may be used. However, if participants go to a physician or hospital affiliated with the preferred provider network, the out-of-pocket costs may be less. Please refer to the Schedule of Benefits for specific information.

Please see the identification card for the participating provider network. Participating physicians within the PPO area can be located at:

SelectFirst™: [www.firstadministrators.com](http://www.firstadministrators.com)

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## PROTECTED HEALTH INFORMATION

### PLAN SPONSOR'S CERTIFICATION OF COMPLIANCE

The Company is the Plan Sponsor of this Plan, unless the participant has been notified, in writing, that another entity is the Plan Sponsor. The Plan, any business associate servicing this Plan, or the Benefit Services Administrator cannot disclose protected health information to the Plan Sponsor unless the Plan Sponsor agrees to abide by the provisions outlined in this section.

The Plan Sponsor of this Plan has provided certification they agree to abide by these provisions.

### PURPOSE OF DISCLOSURE TO PLAN SPONSOR

The Plan, any business associate servicing the Plan, or the Benefit Services Administrator will disclose protected health information to the Plan Sponsor only to permit the Plan Sponsor to administer the Plan consistent with the requirements of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (45 Code of Federal Regulations Parts 160-64). Any disclosure to and use by the Plan Sponsor of protected health information will be subject to and must be consistent with the provisions outlined in the "Restrictions on Plan Sponsor's Use and Disclosure of Protected Health Information" and "Adequate Separation Between the Plan Sponsor and the Plan" sections that follow.

Neither this Plan, the Benefit Services Administrator, nor any business associate servicing the participant's Plan will disclose protected health information to the Plan Sponsor unless the disclosures are explained in the Notice of Privacy Practices distributed to plan participants.

Neither the Plan, the Benefit Services Administrator, nor any business associate servicing this Plan will disclose protected health information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

### RESTRICTIONS ON PLAN SPONSOR'S USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan Sponsor:

- (a) will not use or further disclose protected health information, except as permitted or required by law;
- (b) will ensure that any agent, including any subcontractor, to whom it provides protected health information, agrees to the same restrictions and conditions that apply to the Plan Sponsor;
- (c) will not use or disclose protected health information for employment-related actions or decisions or in connection with any other

benefit or employee benefit plan of the Plan Sponsor;

- (d) will report to the Plan, promptly upon the learning of, any use or disclosure of protected health information that is inconsistent with the uses and disclosures stated in the provisions outlined in this section ("Protected Health Information");
- (e) will make protected health information available to Plan participants in accordance with 45 CFR § 164.524;
- (f) will make protected health information available for amendment, and will, on notice, amend protected health information in accordance with 45 CFR § 164.526;
- (g) will track disclosures it may make of protected health information so that it can provide the information required by the Plan to account for disclosures in accordance with 45 CFR § 164.528; and
- (h) will make its internal practices, books, and records relating to its use and disclosure of protected health information available to this Plan, and to the U.S. Department of Health and Human Services to determine compliance with 45 CFR Parts 160-64.

When protected health information is no longer needed for the plan administrative functions for which the disclosure was made, the Plan Sponsor will, if feasible, return or destroy all protected health information, in whatever form or medium received from the Plan, including all copies of any data or compilations derived from and/or revealing member identity. If it is not feasible to return or destroy all of the protected health information, the Plan Sponsor will limit the use or disclosure of protected health information it cannot feasibly return or destroy to those purposes that make the return or destruction of the information infeasible.

### **ADEQUATE SEPARATION BETWEEN THE PLAN SPONSOR AND THE PLAN**

Certain individuals under the control of the Plan Sponsor may be given access to protected health information received from the Plan, a business associate servicing the group health plan, or the Benefit Services Administrator. This class of employees will be identified by the Plan Sponsor to the Plan and the Benefit Services Administrator from time to time as required under 45 Code of Federal Regulations §164.504. These individuals include all those who may receive protected health information relating to payment under,

health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

These individuals will have access to protected health information only to perform the plan administration functions that the Plan Sponsor provides for the Plan.

Individuals granted access to protected health information will be subject to disciplinary action and sanctions, including loss of employment or termination of affiliation with the Plan Sponsor, for any use or disclosure of protected health information in violation of or noncompliance with the provisions outlined in this section ("Protected Health Information"). The Plan Sponsor will promptly report such violation or noncompliance to the Plan, and will cooperate with the Plan to correct the violation or noncompliance, to impose appropriate disciplinary action or sanctions on each employee causing the violation or noncompliance, and to mitigate any negative effect the violation or noncompliance may have on the member, the privacy of whose protected health information may have been compromised by the violation or noncompliance

### **SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION**

Title II of the Health Insurance Portability and Accountability Act of 1996 and the security regulations issued thereunder (collectively "HIPAA") requires Group Health Plans to secure participants' private health information that it creates, receives, maintains, or transmits electronically. This Plan will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic health information, and will require its agents and contractors to do the same. Reporting of known security incidents to the Plan is part of those safeguards.

This Plan has established safeguards that are supported by reasonable and appropriate security measures to ensure that the Plan does not disclose, or permit one of its agents or contractors to disclose, Protected Health Information to the entity adopting this Plan.

## SCHEDULE OF BENEFITS

Administered by First Administrators, Inc.

**Group: 47005 Black Hills Special Services Cooperative**

Effective Date: September 1, 2011

**Claims must be filed within 12 months from the date of service.**

MEDICAL BENEFITS	PATIENT'S LIABILITY		GENERAL PLAN LIMITS	PAGE
	IN NETWORK	OUT OF NETWORK		
<b>Calendar Year Medical Deductible:</b> - Individual - Family	\$1,000 \$2,000		Common accident provision applies. <i>The In-Network and Out-of-Network deductibles are mutually satisfying.</i>	26
<b>Coinsurance</b>	20%	30%	Coinsurance amounts apply after the deductible has been met, unless otherwise specified.	26
<b>Calendar Year Out-of-Pocket Maximums:</b> - Individual - Family	\$2,000 \$4,000	\$2,500 \$5,000	<b>Includes</b> calendar year deductibles. <i>The In-Network and Out-of-Network maximums are mutually satisfying.</i>	26
<b>Utilization Review:</b> The Utilization Review Program includes Pre-admission certification, Physician review, Continued Stay Review and Discharge Planning. Refer to the Plan Specifications for contact information.				23
<b>Penalty for Non-Compliance:</b> All eligible charges relating to hospital confinement, including hospital, doctor and diagnostic x-ray and lab expenses may be reduced by 20% up to a maximum of \$150 for any single hospitalization if the Participant or Dependent fails to comply with the requirements of this pre-admission utilization review program.				25
<b>Self-Audit Billing Credit:</b> There will be a 25% credit for provider billing errors found by participants up to a maximum of \$500 per calendar year, subject to Section 10.02.				32

**All benefits are subject to the following deductibles, co-pays, coinsurance and maximums unless otherwise stated.**

MEDICAL BENEFITS	PLAN'S LIABILITY		GENERAL PLAN LIMITS	PAGE
	IN NETWORK	OUT OF NETWORK		
Allergy Testing and Injections	80%	70%		33
Ambulance Benefits	80%	70%	To and/or from the hospital if medically necessary.	33
Anesthesia	80%	70%		-
Annual Physical Examination	100%	100%	Paid at 100% for the first \$150 then subject to deductible and coinsurance.	27
Annual Pap Smear and Mammogram	100%	100%	Deductible and coinsurance waived. One pap smear and mammogram per calendar year for employees and dependents.	-
Contraceptives	80%	70%	<b>Includes</b> injectable contraceptives, implantable contraceptives, contraceptive devices and surgical removal of contraceptives.  <b>Excludes</b> oral contraceptives, nuvaring and contraceptive patches. See Prescription Drug benefits.	-
Chiropractic	80%	70%		33
Dental Services Covered Under Medical	80%	70%		27
Durable Medical Equipment	80%	70%	Rental not to exceed the purchase price.	34
Emergency Room Services	80%	80%		-
Hearing Aids	80%	70%	Limited to \$2,000 per lifetime per person.	33
Home Health Care Benefits	80%	70%	Maximum 180 visits per calendar year.	27
Hospice Care Benefits	80%	70%		28
Hospital Benefits	80%	70%	Limited to the semi-private room rate for the level of care the patient is receiving.	28

**This Schedule is a brief summary of benefits. Please review this entire Summary Plan Description for complete benefits.**

**MEDICAL SCHEDULE OF BENEFITS (Continued)**

<b>All benefits are subject to the following deductibles, co-pays, coinsurance and maximums unless otherwise stated.</b>				
<b>MEDICAL BENEFITS</b>	<b>PLAN'S LIABILITY</b>		<b>GENERAL PLAN LIMITS</b>	<b>PAGE</b>
	<b>IN NETWORK</b>	<b>OUT OF NETWORK</b>		
Maternity Expense Benefits - Newborn Hospital Expense	80% 80%	70% 70%	Payable for all female participants. <b>Includes</b> professional services and circumcision.	28
Mental Health/Chemical Dependency	80%	70%	<b>Includes</b> alcoholism and residential treatment.	29
Morbid Obesity	80%	70%	<b>Prior approval is required.</b> Lifetime limit of one surgical procedure.	29
Organ and Bone Marrow Transplants - Lodging & meals - Transportation, lodging & meals	80%	70%	<b>Prior approval is required.</b> Daily maximum of \$250..	29
Physician Services	80%	70%		30
Prostate Cancer Screening	100%	100%	Deductible and coinsurance waived. Benefit available for asymptomatic men aged 45 and over.	-
Self-Inflicted Injury	80%	70%		34
Skilled Nursing Facility Benefit	80%	70%	<b>Prior approval is required.</b> Maximum 120 days per confinement. Up to average semi-private room rate.	30
<b>Note: Confinement must start within 14 days of a release from the hospital.</b>				
Supplemental Accident Benefit	100%	100%	First \$300 per accident, if claim is incurred within 90 days of accident, paid in full, deductible and coinsurance waived.	30
Temporomandibular Joint Dysfunction/Orthognathic Surgery	80%	70%		34
Wig	80%	70%	Limited to hair loss due to administration of cytotoxic agents, up to a maximum of \$300 with lifetime limit of one wig.	34
X-ray and Laboratory Services	80%	70%		27

**This Schedule is a brief summary of benefits. Please review this entire Summary Plan Description for complete benefits.**

## PRESCRIPTION DRUG BENEFITS

PRESCRIPTION BENEFITS	PATIENT'S LIABILITY	GENERAL PLAN LIMITS	PAGE
Retail Pharmacy	80%.	Medical deductible and out-of-pocket maximums apply. Limited up to a 34-day supply per prescription. Maintenance medication may be filled up to a 90-day supply.	37
Mail Order Pharmacy	80%	Medical deductible and out-of-pocket maximums apply. Maintenance medication may be filled up to a 90-day supply.	

**Items Covered:**

- Drugs or medicines authorized to be distributed by prescription, and insulin;
- Insulin and insulin needles/syringes, test strips and tablets, and lancets;
- Impotence drugs when medically necessary. Prior authorization is required;
- Compounded medication of which at least one ingredient is a prescription legend drug;
- Retin-A for non-cosmetic purposes requires prior authorization for covered persons over age 35;
- Oral Contraceptives, nuvaring and patches;
- Prenatal vitamins.

**Items NOT Covered:**

- Drugs or medicines, except for insulin, which are lawfully obtainable without the prescription of a physician, whether or not such drugs are actually obtained by prescription;
- Prescription drugs which may be properly received without charge under local, state, or federal governmental programs, including Worker's Compensation or similar laws;
- Refilling of a prescription in excess of the number specified by the Physician, or any refill dispensed after one year from the date of order of the Physician;
- Drugs labeled: "Caution--limited by federal law to investigational use," or experimental drugs, even though a charge is made;
- Therapeutic devices or appliances, including hypodermic needles, syringes, support garments and other non-medical substances, except for diabetic supplies;
- Contraceptive devices or injections (see Section 5.03 for coverage under the Medical Benefits);
- Drugs for cosmetic purposes, such as Minoxidil (Rogaine), Eflornithine (Vaniqa), and Tretinoin (Retin A);
- Vitamins;
- Immunization agents, biological sera, blood or blood plasma;
- Charges in connection with rest or custodial care, personal comfort items, health club dues or fees for weight loss clinics;
- Smoking cessation prescriptions, products, and programs;
- Infertility drugs with no other approved indication;
- Drugs for weight loss and appetite suppressants;
- Medication which is to be taken by or administered to the covered person, in whole or in part, while a patient in a hospital, rest home, sanitarium, extended care 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..

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## COVERAGE AND ELIGIBILITY

### EMPLOYEE ELIGIBILITY

For employees who are Class 2, 4, or 5 Salaried employees that work at least 20 hours per week or Class 1 or 5 Salaries employees that work at least ninety (90) days per year on an active full-time basis, eligibility for coverage under this Plan begins when you are “actively at work”. Coverage begins after satisfaction of the waiting period, completion of the enrollment application provided by the Plan Administrator, and authorization of payment of your cost of coverage, if any, through payroll deduction.

### EMPLOYEE ENROLLMENT AND EFFECTIVE DATE

Employees will be effective on the first day of the following month if employed on the first day of the month. (Example: hired January 1 effective February 1). If employed on any other day of the month the effective date will be the first day of the second month following employment. (Example: hired January 2 effective March 1 or hired January 16<sup>th</sup> effective March 1)

If the employee is eligible for coverage, but not actively at work on the day his/her coverage is scheduled to begin because of any reason other than his/her own medical condition or disability, this Plan will become effective the day the employee returns to active work. This actively at work provision will not delay the effective date of coverage if the sole reason the employee is not working is because the day is not a regularly scheduled work day.

If the employee does not apply to become a covered participant by completing an enrollment form or application within the 31-day period following the waiting period, he/she will be considered a late enrollee under this Plan. Late enrollee’s will be subject to a 12-month waiting period. At the end of the 12-month waiting period late enrollee’s are eligible to join the plan with no pre-existing condition exclusion period. This Plan will be effective on the first day following completion of the waiting period.

In some cases, there may be “special” circumstances that will allow an employee to enroll for coverage without being considered a late enrollee. For further details on these

circumstances, see the **Special Enrollment Periods** section.

A covered employee who elects to become a covered dependent under this Plan may do so and he/she will be deemed to have completed his/her pre-existing condition exclusion period to the extent that it was satisfied under this Plan as a covered employee on the date of the transfer of coverage.

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### Re-hired Employees

Should an employee leave the active service of the Employer, terminate coverage under the Plan, and be re-hired as an eligible employee by the Employer within 12 months, the eligibility waiting period will be waived. However, the Pre-Existing Conditions Exclusion Period will apply to all employees who are re-hired and to their eligible dependents. Continuation of Plan coverage after employment termination, if elected, shall not extend the 12-month time frame provided for in this paragraph.

### EMPLOYEE TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month in which the covered employee’s active employment with the company is terminated;
- (b) the last day of the month the covered employee ceases to be in a class of employees eligible for coverage;
- (c) the end of the period for which the employee has made contributions if he/she fails to make the next required contribution;
- (d) the end of the month for which the participant’s contract expires;
- (e) the date this Plan is terminated with respect to the company, and there is no successor plan.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any medical or prescription drug services after the termination date even though these services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

## Leave of Absence

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A continuation of benefits is available for up to 12 months as approved by the employer. Other Continuation of Benefits options are available if the leave of absence continues beyond 12 months; see the **Coverage Continuation Under Federal Law** section.

## RETIREE ELIGIBILITY

A continuation of benefits may be purchased after Early Retirement by Plan participants who have qualified for retirement benefits if **each** of the following conditions is met:

- (a) retirees must be at least 55 years of age;
- (b) retirees have 10 or more years of service with the Employer at the time of retirement;
- (c) are currently participating in the group insurance Plan; and
- (d) must qualify for retirement per their specific negotiated agreement.

## RETIREE ENROLLMENT AND EFFECTIVE DATE

Retired employees and their covered dependents are eligible to continue coverage under this Plan provided each of the conditions listed in the previous section are met. Furthermore, on the date of retirement, coverage will continue as long as the retiree has elected to continue this coverage and there is no break in coverage.

## RETIREE TERMINATION OF COVERAGE

Such continuation must terminate at age 65 or when the retiree becomes eligible for Medicare due to age. If at the time the retiree participant becomes eligible for Medicare, and has dependent(s) not eligible for Medicare, coverage for those dependents(s) may be continued under this Plan. Such continuation may be purchased by the spouse of a retiree after the retiree's coverage terminates until the spouse is eligible for Medicare due to age. Such continuation may be purchased by an eligible dependent (other than spouse), of a retiree after the retiree's coverage terminates, for a maximum of 36 months or until the dependent reaches age 65, or is eligible for Medicare, whichever is shorter. (In the event Federal law increases the eligibility age for Medicare, this Plan will abide by the Federal law requirements.)

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any medical or prescription drug services after the termination date even though these services are furnished as a result of an injury or illness that occurred prior to termination of coverage.

## DEPENDENT ELIGIBILITY

A covered employee or retiree may choose to cover his/her dependents (as defined) under this Plan.

A covered employee's dependent children may be covered until they reach the age of 26, unless a full-time student who reaches age 24 on or after July 1, 2007, then coverage will continue to age 29, with an option to purchase single continuation coverage for up to 36 additional months.

In the event a dependent child between the ages of 26 and 29 and a full-time student was married and after divorce meets all other criteria established by this Plan, such child may be covered under this Plan only after submitting a written request for late enrollment as required in this Plan.

If both parents are covered under this Plan as employees, a child can be covered as a dependent of only one parent. No one covered under this Plan as an employee can also be covered as a dependent.

## Michelle's Law: Coverage of Dependent Students on Medically Necessary Leave of Absence

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In the case of an eligible dependent child, this Plan shall not terminate coverage due to a medically necessary leave of absence from, or any other change in enrollment at, a post-secondary education institution that commences while such dependent child is suffering from a serious illness or injury that causes such dependent child to lose student status for purposes of coverage under this Plan, before the earlier of:

- (a) up to one year after the beginning of the leave of absence; or
- (b) the date coverage would otherwise terminate under the Plan.

For the student to qualify for this extension, the plan must receive written certification from his/her treating physician stating that the student is suffering from a serious illness or injury and that the leave of absence is medically necessary.

A student will qualify for a medically necessary leave of absence from a post-secondary educational institution if the leave of absence:

- (a) begins while the child is suffering from a serious illness or injury;
- (b) is certified by a physician as being medically necessary; and
- (c) causes the child to lose student status for purposes of coverage under the plan.

If the dependent child's treating physician does not provide written documentation that the child is suffering from a serious illness or injury and that the leave of absence is medically necessary, this Plan will not provide continued coverage.

### **Adopted Child**

The term "dependent" found in this Plan shall include any child meeting the dependent eligibility requirements of this Plan who has been placed for adoption or who has been adopted by the participant.

Such a child shall be eligible for coverage as of the date of placement for adoption, or as of the date of actual adoption, whichever occurs first.

Coverage under this Plan for the adopted child shall be the same coverage which is available to all other dependent children under this Plan except that additional waiting periods will be waived for such a child provided the child is enrolled within the time periods specified under the section entitled **Dependent Enrollment and Effective Date**.

### **QMCSO Provision**

This Plan will provide benefits to the child(ren) of a participant if a Qualified Medical Child Support Order (QMCSO) is issued regardless of whether the child(ren) reside with the participant. If a QMCSO is issued, then the child(ren) shall become alternate recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other participant. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

### **Procedural QMCSO Requirements**

Within a reasonable period of time following receipt of a medical child support order, the Plan Administrator will notify the participant and each child specified in the order whether the order is or is not a Qualified Medical Child Support Order. A QMCSO is an order which creates or recognizes

the right of an alternate recipient (participant's child who is recognized under the order as having a right to be enrolled under this Plan) or assigns to the alternate recipient the right to receive benefits. To be considered a Qualified Medical Child Support Order, the medical child support order must contain the following information:

- (a) The name and last known mailing address of the participant and the name and address of each child to be covered by this Plan.
- (b) A reasonable description of the type of coverage to be provided by this Plan to each named child, or the manner in which the type of coverage is to be determined.
- (c) The period to which such order applies.

If the order **is** determined to be a Qualified Order, each named child will be covered by this Plan in the same manner as any other dependent child is covered by this Plan.

Coverage for a child under a QMCSO will begin on the latest of the following dates:

- (a) If the employee already has coverage in force, the child will be covered as of the date specified in the order or, if no date is specified in the Order, the date the QMCSO is received;
- (b) If the employee is within the waiting period as specified under the section entitled "Effective Date" the child's coverage will become effective the same date the employee's coverage is effective; or
- (c) If the employee is otherwise eligible but previously waived coverage, the employee's and the child's coverage will become effective as of the date specified in (a) above.

Each named child will be considered a participant under this Plan but may designate another person, such as a custodial parent or legal guardian, to receive copies of explanations of benefits, checks and other material which would otherwise be sent directly to the named child.

If it is determined that the order **is not** a Qualified Order, each named child may appeal that decision by submitting a written letter of appeal to the Plan Administrator. The Plan Administrator shall review the appeal and reply in writing within 30 days of receipt of the appeal.

This Plan will not provide any type or form of benefit, or any option, not otherwise provided under this Plan and all other dependent eligibility,

effective date and termination provisions will apply.

## DEPENDENT ENROLLMENT AND EFFECTIVE DATE

Generally, coverage for dependents will become effective on the same day the employee's coverage begins. Any new dependent can become a covered dependent as of one of the following applicable dates:

- (a) the eligibility date for which written application is made and delivered to the Plan Administrator, if made on or before the date the individual becomes a dependent;
- (b) the eligibility date for which such written application is received when the application is made and delivered to the Plan Administrator within 31 days after the individual becomes a dependent; or
- (c) the eligibility date determined under the terms of an applicable special enrollment period. In some cases, such as marriage, birth, adoption, and placement for adoption, there may be special circumstances that will allow a dependent to enroll for coverage after the initial enrollment period without being considered a late enrollee. For further details on these circumstances, see the section on **Special Enrollment Periods**.

A covered dependent who becomes eligible as an employee under this Plan will be considered to have satisfied his/her waiting period and his/her pre-existing condition exclusion period on the date he/she becomes so eligible if, on that date, he/she has fully satisfied the waiting period and pre-existing condition exclusion period.

If the employee is absent from active work because of any reason other than his/her medical condition or disability when coverage for his/her dependents would otherwise take effect, coverage for the dependents will become effective only upon the employee's return to active work.

## DEPENDENT TERMINATION OF COVERAGE

Coverage will end on the earliest of the following dates:

- (a) the last day of the month in which the dependent ceases to be a covered dependent as defined by this Plan;
- (b) in the event of a legal separation or divorce, coverage for the employee's spouse will cease the end of the month in which the event occurred;
- (c) the last day of the month the covered dependent ceases to be in a class of dependents eligible for coverage;
- (d) the end of the period for which the employee has made contributions for a dependent's coverage if the next required contribution is not made;
- (e) the last day of the month this Plan is terminated with respect to the company, and there is no successor plan.

Unless otherwise specified under this Plan, when coverage terminates, benefits will not be provided for any for medical or prescription drug services after the termination date even though these services are furnished as a result of an injury that occurred prior to termination of coverage.

## SPECIAL ENROLLMENT PERIODS

Special Enrollment rights are provided both to current employees who were eligible but declined enrollment in the Plan when first offered because they were covered under another plan and to individuals acquiring a dependent.

This Plan will permit a current employee who is already enrolled in a plan option to enroll in another plan option under this Plan in the event of a Special Enrollment right.

Pre-existing condition exclusion periods for special enrollees may not exceed 12 months.

### Individuals Losing Other Coverage

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This Plan will permit a current employee or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if **each** of the following conditions is met:

- (a) the current employee or dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;
- (b) the current employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the current employee having coverage under another group health plan or due to the

employee having other health insurance coverage, but only if this Plan required such a written statement at that time and provided the current employee with notice of the requirement (and consequences of the requirement) at that time;

- (c) the current employee or dependent lost other coverage pursuant to one of the following events:
- the current employee or dependent was under COBRA and the COBRA coverage was exhausted;
  - the current employee or dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of legal separation, divorce, loss of dependent status, death, termination of employment, or reduction in the number of hours worked);
  - the current employee or dependent moved out of an HMO service area with no other option available;
  - the current employee or dependent met or exceeded a lifetime limit on all benefits (the event for reaching the lifetime limit is the earliest date that a claim is denied);
  - the Plan is no longer offering benefits to a class of similarly situated individuals;
  - the benefit package option is no longer being offered and no substitute is available; or
  - the employer contributions were terminated; and
- (d) under the terms of this Plan, the current employee requests enrollment into this Plan not later than 63 days after an event, as described in (c) above.

For an eligible current employee or dependent who has met **each** of the conditions specified above, this Plan will be effective no later than the first day of the first calendar month as long as the written request for enrollment is made within 63 days from loss of coverage.

This Plan will also permit a current employee or dependent who is eligible, but not enrolled, to enroll for coverage under the terms of this Plan if the current employee or dependent lost eligibility under Medicaid or CHIP.

The current employee must request enrollment into this Plan not later than 60 days after the event, as described above.

For an eligible current employee or dependent who has met the conditions specified above, this Plan will be effective no later than the first day of the first calendar month as long as the written request for enrollment is made within the required days from loss of coverage.

### **Dependent Beneficiaries**

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This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee (and, if not otherwise enrolled, the current employee and/or other eligible dependent may be enrolled at the same time) if:

- (a) the current employee has coverage under this Plan (or the current employee has met any waiting period applicable to becoming covered under this Plan and is eligible to be enrolled under this Plan, but failed to enroll during a previous enrollment period); and
- (b) a person becomes a dependent of the current employee through marriage, birth, or adoption or placement for adoption.

In the case of the birth or adoption of a child, the spouse, and/or other dependents of the current employee may also be enrolled as a dependent if the spouse and/or other eligible dependents are otherwise eligible for coverage.

The dependent special enrollment period will be a period of 31 days beginning on the date of marriage, birth, adoption or placement for adoption.

If a current employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective:

- (a) in the case of marriage, not later than the first day of the first month, as long as the written request for enrollment is made within 31 days of marriage.
- (b) in the case of a dependent's birth, as of the date of birth, provided the written request for enrollment occurs within 31 days of birth; or
- (c) in the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption provided the written request for enrollment occurs within 31 days of birth;.

This Plan will provide for a dependent special enrollment period during which the person may be enrolled under this Plan as a dependent of the current employee (and, if not otherwise enrolled, the current employee, spouse and/or other eligible dependent may be enrolled at the same time) if:

- (a) the current employee or dependent becomes eligible for a new premium assistance subsidy plan under Medicaid or CHIP.

This dependent special enrollment period will be a period of 60 days beginning on the date of eligibility.

If a current employee requests enrollment for a dependent during the dependent special enrollment period, the coverage for the dependent will become effective as of the date of eligibility.

## **DEPENDENT CHILDREN WITH DISABILITIES**

Coverage of an unmarried dependent child shall not cease because of attainment of the termination age specified in this Plan, while the employee's coverage is in force and the child otherwise qualifies as a dependent, if the child:

- (a) is incapable of self-sustaining employment by reason of a handicapping mental or physical disability; and
- (b) became so disabled prior to attainment of the termination age specified in this Plan.

The employee or must submit to the Plan Administrator, within 30 days of such dependent's attainment of the termination age, written proof of the disability as described and continue to pay premiums, if any, for the dependent's coverage. The coverage of any such dependent will be subject to all other termination provisions of this Plan.

The Benefit Services Administrator, upon receipt of proof of the disability, shall have the right and opportunity to have a physician it designates examine any such dependent when and as often as the Benefit Services Administrator reasonably require. The Benefit Services Administrator will not require the dependent to be examined more than once each year after such disability has continued on an uninterrupted basis for at least two years following the date the initial written proof of disability was received.

All rights under the provisions of this section shall automatically and immediately cease on the earliest of the following dates:

- (a) the date the dependent's disability as described no longer exists;
- (b) the date the dependent fails to submit to any required medical examination;
- (c) the date the employee fails to submit any required proof of the uninterrupted existence of the dependent's disability; or
- (d) the date the dependent otherwise ceases to qualify as a dependent except for the attainment of the maximum age as specified by this Plan.

## **FRAUD OR MISREPRESENTATION OF MATERIAL FACTS**

Coverage will terminate immediately if a participant uses this Plan fraudulently or fraudulently misrepresents a material fact in his/her application.

If coverage is terminated for fraud or misrepresentation of a material fact, the Plan has the right to recover any/all claim payments and retains the right to pursue any/all other legal rights, including the right to bring a civil action.

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## THE UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

The Plan Sponsor shall fully comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). If any part of this Plan is found to be in conflict with this Act, the conflicting provision shall be null and void. All other benefits and exclusions of the Plan will remain effective to the extent there is no conflict with this Act.

USERRA provides for, among other employment rights and benefits, continuation of health care coverage to a covered employee and covered dependents, during a period of active service or training with any of the Uniformed Services. The Plan provides that a covered employee may elect to continue such coverages in effect at the time the employee is called to active service. The maximum period of coverage for the employee and the covered employee's dependents under such an election shall be the lesser of:

- (a) the 24-month period beginning on the date on which the covered employee's absence begins; or
- (b) the period beginning on the date on which the covered employee's absence begins and ending on the day after the date on which the covered employee fails to apply for or return to a position of employment as follows:
  - for service of less than 31 days, no later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of the period of service and the expiration of eight hours after a period allowing for the safe transportation from the place of service to the covered employee's residence or as soon as reasonably possible after such eight hour period;
  - for service of more than 30 days but less than 181 days, no later than 14 days after the completion of the period of service or as soon as reasonably possible after such period;

- for service of more than 180 days, no later than 90 days after the completion of the period of service; or
- for a covered employee who is hospitalized or convalescing from an illness or injury incurred in or aggravated during the performance of service in the uniformed services, at the end of the period that is necessary for the covered employee to recover from such illness or injury. Such period of recovery may not exceed two years.

A covered employee who elects to continue health plan coverage under the Plan during a period of active service in the Uniformed Services may be required to pay not more than 102% of the full premium under the plan associated with such coverage for the employer's other employees, except that in the case of a covered employee who performs service in the uniformed services for less than 31 days, such covered employee may not be required to pay more than the employee share, if any, for such coverage. Continuation coverage cannot be discontinued merely because activated military personnel receive health coverage as active duty members of the Uniformed Services, and their family members are eligible to receive coverage under the Department of Defense's managed health care program, TRICARE.

In the case of a covered employee whose coverage under a health plan was terminated by reason of services in the Uniformed Services, the pre-existing exclusion and waiting period may not be imposed in connection with the reinstatement of such coverage upon reemployment under this Act. This applies to the covered employee who is reemployed and any dependent whose coverage is reinstated. The waiver of the pre-existing exclusion shall not apply to illness or injury which occurred or was aggravated during performance of service in the Uniformed Services.

"Uniformed Services" shall include full time and reserve components of the United States Army, Navy, Air Force, Marines, Coast Guard, Army National Guard, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If the covered employee is called to a period of active service in the Uniformed Service, he/she should check with the Plan Administrator for a more complete explanation of rights and obligations under USERRA.

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## **FAMILY AND MEDICAL LEAVE ACT OF 1993**

**T**his Section only applies to employers required to comply with the Federal Family and Medical Leave Act.

### **ENTITLEMENT TO LEAVE**

This Act requires an employer which employs 50 or more employees (within a 75-mile radius) to allow an employee who has been employed for 12 months or more and accumulated hours of service in excess of 1,250 hours from the date of employment or the end of the last qualified leave, to take a total of 12 weeks of leave during any 12-month period, as defined by the employer, for:

- (a) the birth of a son or daughter of the employee and in order to care for such son or daughter;
- (b) placement of a son or daughter with the employee for adoption or foster care;
- (c) care for a spouse, son, daughter, or parent of the employee, if such spouse, son, daughter, or parent has a serious health condition;
- (d) a serious health condition that makes the employee unable to perform the functions of the position of such employee; or
- (e) a qualifying exigency arising out of the fact that the spouse, son, daughter, or parent of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

### **EXPIRATION OF ENTITLEMENT**

The entitlement to leave under subparagraphs (a) and (b) of Entitlement of Leave for a birth or placement of a son or daughter shall expire at the end of the 12-month period beginning on the date of such birth or placement.

### **SERVICEMEMBER FAMILY LEAVE**

An eligible employee who is the spouse, son, daughter, parent or next of kin of a covered servicemember shall be entitled to a total of 26 workweeks of leave during a single 12-month period to care for the servicemember. The leave described in this paragraph shall only be available during a single 12-month period.

### **COMBINED TOTAL LEAVE**

During the single 12-month period as described in Servicemember Family Leave, an eligible employee shall be entitled to a combined total of 26 workweeks of leave under Entitlement to Leave and Servicemember Family Leave. Nothing in this paragraph shall be construed to limit the availability of leave under Entitlement to Leave during any other 12-month period.

Any employee taking a leave shall be entitled to continue to use his/her benefits during the duration of the leave if he/she participates in a "group health plan" as defined in §5000(b)(1) of the Internal Revenue Code of 1986. The employer must continue the benefits at the level and under the conditions of coverage that would have been provided if the employee had remained employed. If the employee who is responsible for payment misses a premium payment during the leave of absence, the employer may terminate coverage provided that the employee has been given notification of termination and a grace period as defined by the FMLA. If the benefits are terminated during the leave, the employee is entitled to be fully reinstated upon returning to work. If the employee for any reason fails to return from the leave, the employer may recover from the employee the premium or portion of the premium that the employer paid, provided the employee fails to return to work for any reason other than the recurrence of the health condition or circumstances beyond the control of the employee.

Leave taken under the Act does not constitute a "qualifying event" so as to trigger COBRA rights. However, a qualifying event triggering COBRA coverage may occur when it becomes known that the employee is not returning to work. Therefore, if an employee does not return at the end of 12 weeks Family and Medical Leave, the COBRA qualifying event occurs at that time.

This is only a summary of the Family and Medical Leave Act of 1993. Please contact the employer for more information.

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## **COVERAGE CONTINUATION UNDER FEDERAL LAW - COBRA**

**T**he following information about the participant's right to continue his/her health care coverage in the Plan is important. Please read it very carefully.

COBRA continuation coverage is a temporary extension of group health coverage under the Plan under certain circumstances when coverage would otherwise end. The right to COBRA coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA coverage can become available to the participant when he/she would otherwise lose group health coverage under the Plan. It can also become available to the employee's spouse and dependent children, if they are covered under the Plan, when they would otherwise lose their group health coverage under the Plan. The following paragraphs generally explain COBRA coverage, when it may become available to the employee and his/her family, and what the participant needs to do to protect the right to receive it.

COBRA (and the description of COBRA coverage contained in this Plan) applies only to the benefits offered under the Plan and not to any other benefits offered under the Plan or by Black Hills Educational Benefits Cooperative (such as life insurance, disability, or accidental death or dismemberment benefits). The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the participant's rights beyond COBRA's requirements.

For additional information about rights and obligations under the Plan and under federal law, the participant should contact Black Hills Special Services, which is the Plan Administrator or First Administrators, Inc., which is the Benefits Services Administrator.

### **WHAT IS COBRA COVERAGE?**

COBRA coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event". Specific qualifying events are listed below in the section entitled "Who is Entitled to Elect COBRA?".

After a qualifying event occurs and any required notice of that event is properly provided to the Plan Administrator, COBRA coverage must be offered to each person losing Plan coverage who is a "qualified beneficiary". The employee, his/her spouse, and dependent children could become qualified beneficiaries and would be entitled to elect COBRA if coverage under the Plan is lost because of the qualifying event. (Certain newborns, newly adopted children, and alternate recipients under QMCSO's may also be qualified beneficiaries. This is discussed in more detail in separate paragraphs below.)

COBRA coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving COBRA coverage. Each qualified beneficiary who elects COBRA will have the same rights under the Plan as other participants or beneficiaries covered under the component or components of the Plan elected by the qualified beneficiary, including open enrollment and special enrollment rights. Under the Plan, qualified beneficiaries who elect COBRA must pay for COBRA coverage.

Additional information about the Plan is available in other portions of this Plan.

### **WHO IS ENTITLED TO ELECT COBRA?**

The employee will be entitled to elect COBRA if he/she lose his/her group health coverage under the Plan because his/her hours of employment are reduced; or his/her employment ends for any reason other than his/her gross misconduct.

As the spouse of an employee, the spouse will be entitled to elect COBRA if he/she loses his/her group health coverage under the Plan because any of the following qualifying events happens:

- (a) the employee dies;
- (b) the employee's hours of employment are reduced;
- (c) the employee's employment ends for any reason other than his or her gross misconduct;
- (d) the employee becomes entitled to Medicare benefits prior to his/her qualifying event; or
- (e) the spouse becomes divorced or legally separated from the employee.

As the dependent child of an employee, the dependent child will be entitled to elect COBRA if he/she lose his/her group health coverage under

the Plan because any of the following qualifying events happens:

- (a) the parent-employee dies;
- (b) the parent-employee's hours of employment are reduced;
- (c) the parent-employee's employment ends for any reason other than his or her gross misconduct;
- (d) the parent-employee becomes entitled to Medicare benefits;
- (e) the parents become divorced or legally separated; or
- (f) the dependent stops being eligible for coverage under the Plan as a "dependent child".

If an employee takes FMLA leave and does not return to work at the end of the leave, the employee (and the employee's spouse and dependent children, if any) will be entitled to elect COBRA if (1) they were covered under the Plan on the day before the FMLA leave began (or became covered during the FMLA leave); and (2) they will lose Plan coverage because of the employee's failure to return to work at the end of the leave. (This means that some individuals may be entitled to elect COBRA at the end of an FMLA leave even if they were not covered under the Plan during the leave.) COBRA coverage elected in these circumstances will begin on the last day of the FMLA leave, with the same 18-month maximum coverage period (subject to extension or early termination) generally applicable to the COBRA qualifying events of termination of employment and reduction of hours. (See the section below entitled "Length of COBRA Coverage".)

## **WHEN IS COBRA COVERAGE AVAILABLE?**

When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the Plan will offer COBRA coverage to qualified beneficiaries. The participant need not notify the Plan Administrator of any of these three qualifying events.

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), a COBRA election will be available only if the participant notifies the Benefit Service Administrator in writing within 60 days after the later of (1) the date of the qualifying

event; and (2) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the qualifying event.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

If these procedures are not followed, or if the written notice is not provided to the Plan Administrator during the 60-day notice period, **THE PARTICIPANT WILL LOSE HIS/HER RIGHT TO ELECT COBRA.**

## **ELECTING COBRA COVERAGE**

To elect COBRA, the participant must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the Benefit Service Administrator. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. The participant may also obtain a copy of the Election Form from the Benefit Service Administrator. Under federal law, the participant must have 60 days after the date the qualified beneficiary plan coverage terminates, or, if later, 60 days after the date of the COBRA election notice provided to him/her at the time of his/her qualifying event to decide whether he/she wants to elect COBRA under the Plan.

Mail the completed Election Form to:

COBRA Department  
First Administrators, Inc.  
PO Box 8150  
Rapid City, SD 57709-8150

The Election Form must be completed in writing and mailed to the individual and address specified above. The following are not acceptable as COBRA elections and will not preserve COBRA rights: oral communications regarding COBRA coverage, including in-person or telephone statements about an individual's COBRA coverage, and electronic communications, including email and faxed communications.

The election must be postmarked no later than 60 days after the date of the COBRA election notice provided at the time of the qualifying event. **IF THE PARTICIPANT DOES NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, HE/SHE WILL LOSE HIS OR HER RIGHT TO ELECT COBRA.**

If the participant rejects COBRA before the due date, he/she may change his/her mind as long as he/she furnishes a completed Election Form before the due date. The Plan will only provide continuation coverage beginning on the date the waiver of coverage is revoked.

The participant does not have to send any payment with his/her Election Form when he/she elect COBRA. Important additional information about payment for COBRA coverage is included below.

Each qualified beneficiary will have an independent right to elect COBRA. For example, the employee's spouse may elect COBRA even if the employee does not. COBRA may be elected for only one, several, or for all dependent children who are qualified beneficiaries. Covered employees and spouses (if the spouse is a qualified beneficiary) may elect COBRA on behalf of all of the qualified beneficiaries, and parents may elect COBRA on behalf of their children. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

When the participant completes the Election Form, he/she must notify the Benefit Service Administrator if any qualified beneficiary has become entitled to Medicare and, if so, the date of Medicare entitlement. If the participant becomes entitled to Medicare (or first learns that he/she is entitled to Medicare) after submitting the Election Form, immediately notify the Benefit Service Administrator of the date of the Medicare entitlement at the address specified above for delivery of the Election Form.

Qualified beneficiaries who are entitled to elect COBRA may do so even if they have other group health plan coverage or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, as discussed in more detail below, a qualified beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare benefits or becomes covered under other group health plan coverage (but only after any applicable pre-existing condition exclusions of that other plan have been exhausted or satisfied). See the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period".

## **SPECIAL CONSIDERATIONS IN DECIDING WHETHER TO ELECT COBRA**

In considering whether to elect COBRA, the participant should take into account that a failure to elect COBRA will affect his/her future rights under federal law. First, he/she can lose the right to avoid having pre-existing condition exclusions applied to the participant by other group health plans if he/she has a 63-day gap in health coverage, and election of COBRA may help avoid such a gap. Second, the participant will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if he/she elect COBRA coverage and does not exhaust COBRA coverage for the maximum time available. Finally, the participant should take into account that he/she has special enrollment rights under federal law. The participant has the right to request special enrollment in another group health plan for which he/she is otherwise eligible (such as a plan sponsored by the spouse's employer) within 30 days after the participant's group health coverage under the Plan ends because of one of the qualifying events listed above. The participant will also have the same special enrollment right at the end of COBRA coverage if he/she gets COBRA coverage for the maximum time available.

## **LENGTH OF COBRA COVERAGE**

COBRA coverage is a temporary continuation of coverage. The COBRA coverage periods described below are maximum coverage periods. COBRA coverage can end before the end of the maximum coverage period for several reasons, which are described in the section below entitled "Termination of COBRA Coverage Before the End of the Maximum Coverage Period".

When Plan coverage is lost due to the death of the employee, the covered employee's divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA coverage can last for up to a total of 36 months.

When Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can last until up to 36 months after the date

of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage under the Plan's Medical and Dental components for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus eight months). This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Otherwise, when Plan coverage is lost due to the end of employment or reduction of the employee's hours of employment, COBRA coverage generally can last for only up to a total of 18 months.

## **EXTENSION OF MAXIMUM COVERAGE PERIOD**

If the qualifying event that resulted in the participant's COBRA election was the covered employee's termination of employment or reduction of hours, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. The participant must notify the Benefit Service Administrator of a disability or a second qualifying event in order to extend the period of COBRA coverage. Failure to provide notice of a disability or second qualifying event will eliminate the right to extend the period of COBRA coverage. Along with the notice of a disability, the qualified beneficiary must also supply a copy of the Social Security Administration disability determination.

If a qualified beneficiary is determined by the Social Security Administration to be disabled and the participant notifies the Benefit Service Administrator in a timely fashion, all of the qualified beneficiaries in the family may be entitled to receive up to an additional 11 months of COBRA coverage, for a total maximum of 29 months. This extension is available only for qualified beneficiaries who are receiving COBRA coverage because of a qualifying event that was the covered employee's termination of employment or reduction of hours. The qualified beneficiary must be determined disabled at any time during the first 60 days of COBRA coverage. Each qualified beneficiary will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the participant notifies the Benefit Service Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- (a) the date of the Social Security Administration's disability determination;
- (b) the date of the covered employee's termination of employment or reduction of hours; or
- (c) the date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan as a result of the covered employee's termination of employment or reduction of hours.

The written notice must include the plan name or group name, the employee's name, the employee's Social Security Number, the dependent's name and a description of the event.

The participant must also provide this notice within 18 months after the covered employee's termination of employment or reduction of hours in order to be entitled to a disability extension.

If these procedures are not followed or if the written notice is not provided to the Benefit Service Administrator during the 60-day notice period and within 18 months after the covered employee's termination of employment or reduction of hours, **THEN THERE WILL BE NO DISABILITY EXTENSION OF COBRA COVERAGE.**

An extension of coverage will be available to spouses and dependent children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the covered employee's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a covered employee becomes entitled to Medicare.)

This extension due to a second qualifying event is available only if the participant notifies the Benefit Service Administrator in writing of the second qualifying event within 60 days after the later of (1) the date of the second qualifying event; and (2) the date on which the qualified beneficiary would lose coverage under the terms of the Plan as a result of the second qualifying event (if it had occurred while the qualified beneficiary was still covered under the Plan).

If these procedures are not followed or if the written notice is not provided to the Benefit Service Administrator during the 60-day notice period, **THERE WILL BE NO EXTENSION OF COBRA COVERAGE DUE TO A SECOND QUALIFYING EVENT.**

In addition to the regular COBRA termination events specified later in this section, the disability extension period will end the first of the month beginning more than 30 days following recovery.

**Example:** If disability ends June 10, coverage will continue through the month of July (7/31).

## **TERMINATION OF COBRA COVERAGE BEFORE THE END OF THE MAXIMUM COVERAGE PERIOD**

COBRA coverage will automatically terminate before the end of the maximum period if:

- (a) any required premium is not paid in full on time;
- (b) a qualified beneficiary becomes covered, after electing COBRA, under another group health plan (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied);
- (c) a qualified beneficiary becomes entitled to Medicare benefits after electing COBRA;
- (d) the employer ceases to provide any group health plan for its employees; or
- (e) during a disability extension period, the disabled qualified beneficiary is determined by the Social Security Administration to be no longer disabled. For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period".

COBRA coverage may also be terminated for any reason the Plan would terminate coverage of a

participant or beneficiary not receiving COBRA coverage (such as fraud).

The participant must notify the Benefit Service Administrator in writing within 30 days if, after electing COBRA, a qualified beneficiary becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any pre-existing condition exclusions of that other plan for a pre-existing condition of the qualified beneficiary have been exhausted or satisfied).

COBRA coverage will terminate (retroactively if applicable) as of the date of Medicare entitlement or as of the beginning date of the other group health coverage (after exhaustion or satisfaction of any pre-existing condition exclusions for a pre-existing condition of the qualified beneficiary). The Plan Administrator will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Benefit Service Administrator of Medicare entitlement or other group health plan coverage.

If a disabled qualified beneficiary is determined by the Social Security Administration to no longer be disabled, the participant must notify the Benefit Service Administrator of that fact within 30 days after the Social Security Administration's determination.

If the Social Security Administration's determination that the qualified beneficiary is no longer disabled occurs during a disability extension period, COBRA coverage for all qualified beneficiaries will terminate (retroactively if applicable) as of the first day of the month that is more than 30 days after the Social Security Administration's determination that the qualified beneficiary is no longer disabled. Black Hills Educational Benefits Cooperative will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when the participant provides notice to the Benefit Service Administrator that the disabled qualified beneficiary is no longer disabled. (For more information about the disability extension period, see the section above entitled "Extension of Maximum Coverage Period".)

## **COST OF COBRA COVERAGE**

Each qualified beneficiary is required to pay the entire cost of COBRA coverage. The amount a qualified beneficiary may be required to pay may not exceed 102% (or, in the case of an extension of COBRA coverage due to a disability, 150%) of the cost to the group health plan (including both

employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA coverage. The amount of the COBRA premiums may change from time to time during the period of COBRA coverage and will most likely increase over time. The participant will be notified of COBRA premium changes.

## **PAYMENT FOR COBRA COVERAGE**

All COBRA premiums must be paid by check or money order.

The participant's first payment and all monthly payments for COBRA coverage must be made payable to Black Hills Educational Benefits Cooperative and mailed to:

COBRA Department  
First Administrators, Inc.  
PO Box 8150  
Rapid City, SD 57709-8150

The payment is considered to have been made on the date that it is postmarked. The participant will not be considered to have made any payment by mailing a check if his/her check is returned due to insufficient funds or otherwise.

If the participant elects COBRA, he/she does not have to send any payment with the Election Form. However, he/she must make his/her first payment for COBRA coverage not later than 45 days after the date of election. (This is the date the Election Form is postmarked, if mailed, or the date the Election Form is received by the individual at the address specified for delivery of the Election Form, if hand-delivered). See the section above entitled "Electing COBRA Coverage".

The first payment must cover the cost of COBRA coverage from the time coverage under the Plan would have otherwise terminated up through the end of the month before the month in which the participant makes his/her first payment. For example, Sue's employment terminated on September 30, and she loses coverage on September 30. Sue elects COBRA on November 15. Her initial premium payment equals the premiums for October and November and is due on or before December 30, the 45<sup>th</sup> day after the date of her COBRA election. The participant is responsible for making sure that the amount of his/her first payment is correct. He/she may contact the Benefit Service Administrator to confirm the correct amount of the first payment.

Claims for reimbursement will not be processed and paid until the participant has elected COBRA and made the first payment for it.

If the participant does not make the first payment for COBRA coverage in full within 45 days after the date of his/her election, he/she will lose all COBRA rights under the plan.

After the participant makes his/her first payment for COBRA coverage, he/she will be required to make monthly payments for each subsequent month of COBRA coverage. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided at the time of the qualifying event. Under the Plan, each of these monthly payments for COBRA coverage is due on the first day of the month for that month's COBRA coverage. If the participant makes a monthly payment on or before the first day of the month to which it applies, his/her COBRA coverage under the Plan will continue for that month without any break. The Benefit Service Administrator will not send periodic notices of payments due for these coverage periods (that is, a bill will not be sent for the COBRA coverage – it is the participant's responsibility to pay his/her COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, the participant will be given a grace period of 30 days after the first day of the month to make each monthly payment. COBRA coverage will be provided for each month as long as payment for that month is made before the end of the grace period for that payment. However, if the participant pays a monthly payment later than the first day of the month to which it applies, but before the end of the grace period for the month, his/her coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. This means that any claim submitted for benefits while coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

If the participant fails to make a monthly payment before the end of the grace period for that month, **HE OR SHE WILL LOSE ALL RIGHTS TO COBRA COVERAGE UNDER THE PLAN.**

## **MORE INFORMATION ABOUT INDIVIDUALS WHO MAY BE QUALIFIED BENEFICIARIES**

A child born to, adopted by, or placed for adoption with a covered employee during a period of COBRA coverage is considered to be a qualified beneficiary provided that, if the covered employee is a qualified beneficiary, the covered employee has elected COBRA coverage for himself or herself. The child's COBRA coverage begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment, and it lasts for as long as COBRA coverage lasts for other family members of the employee. To be enrolled in the Plan, the child must satisfy the otherwise applicable Plan eligibility requirements (for example, regarding age).

A child of the covered employee who is receiving benefits under the Plan pursuant to a Qualified Medical Child Support Order (QMCSO) received by the Black Hills Educational Benefits Cooperative during the covered employee's period of employment with Black Hills Educational Benefits Cooperative is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

## **ASSISTANCE WITH QUESTIONS**

Questions concerning the Plan or the participant's COBRA rights should be addressed to the contact or contacts identified below.

## **KEEP THE PLAN INFORMED OF ADDRESS CHANGES**

In order to protect the participant family's rights, he/she should keep the Plan Administrator informed of any changes in the addresses of family members. The participant should also keep a copy, for his/her records, of any notices sent to the Benefit Services Administrator or the Plan Administrator.

## **PLAN CONTACT INFORMATION**

The participant may obtain information about the Plan and COBRA coverage on request from:

COBRA Department  
First Administrators, Inc.  
PO Box 8150  
Rapid City, SD 57709-8150

-or-

Black Hills Educational Benefits Cooperative  
P.O. Box 219  
Sturgis, SD 57785-0219

The contact information for the Plan may change from time to time. The most recent information will be included in the Plan's most recent Summary Plan Description (if the participant is not sure whether this is the Plan's most recent Summary Plan Description, he/she may request the most recent one from the Benefit Services Administrator or the Plan Administrator).

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## **CREDITABLE COVERAGE PROVISION**

**Q**ualifying periods of time during which a participant had "creditable coverage" will be applied toward the satisfaction of the participant's pre-existing condition exclusion period. Prior carriers or employers will provide certification regarding a participant's prior coverage. In addition, the participant may request a certificate of creditable coverage under this Plan at any time from the Benefit Services Administrator or the Plan Administrator, up to 24 months after the participant's coverage ceases. This certification will be used to determine what portion of the participant's pre-existing condition exclusion period, if any, must still be satisfied.

Written requests for Certificates must include:

- (a) the full name of the individual for whom the Certificate is requested;
- (b) the last date that the individual was covered under the plan;
- (c) the name of the participant that enrolled the individual in the plan;
- (d) a telephone number to reach the individual for whom the Certificate is requested, in the event of any difficulties;
- (e) the name of the person making the request and evidence of that person's authority to request and receive the Certificate on behalf of the individual;
- (f) the address to which the Certificate should be mailed; and
- (g) the requestor's signature.

After receiving a request that meets these requirements, the plan will act in a reasonable and prompt fashion to provide the Certificate.

Prior coverage does not qualify under this provision if there is a break in coverage of 63 consecutive days or more. Waiting periods are not considered periods without coverage nor are they counted as creditable coverage. Refer to the **Definitions** section for a definition of "Creditable Coverage".

As required by the Trade Act of 2002, the days between the date an individual loses group health coverage and the first day of the second COBRA election period are not taken into account in determining whether a significant break in coverage has occurred.

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## PRE-EXISTING CONDITION EXCLUSION PERIOD

**T**his Plan includes an exclusion period for participants with pre-existing (not otherwise excludable) medical conditions. A pre-existing medical condition is an injury or illness which was present prior to the participant's date of enrollment (see definition) for which any medical advice, diagnosis, care or treatment (including having a prescription for legend drugs, whether or not the drugs are taken) was provided or recommended by a physician prior to the participant's date of enrollment. Genetic information is not treated as a pre-existing condition in the absence of a diagnosis of a condition related to the genetic information. This pre-existing condition exclusion period will not be applied to any participant or dependent under age 19 and never applies to pregnancy, regardless of whether the woman had previous coverage.

This provision will also be in effect if there is a change in the participant's coverage which the participant elected to make and which increased this Plan's liability.

The pre-existing condition exclusion period works as follows:

If a participant has a pre-existing, allowable medical condition (physical or mental) within the 6-month period prior to his/her date of enrollment for medical coverage (this 6-month period is called the look-back period), that allowable condition will not be covered by this Plan until 12 months following the participant's date of enrollment.

The 12-month pre-existing condition exclusion period will be reduced by the length of the aggregate period of any creditable prior coverage.

This Plan will apply the standard method of counting creditable coverage. The standard method

of counting creditable coverage determines an individual's creditable coverage without reference to specific benefits provided during the individual's prior coverage periods.

The charges incurred during the 12-month pre-existing condition exclusion period will be reviewed by the Benefit Services Administrator and allowable conditions which appear to be pre-existing will be investigated.

Benefits will be available for all covered services with the exception of the allowable condition(s) specifically identified as being pre-existing.

All pre-existing condition exclusion periods (and accompanying 6-month look-back periods) for *special enrollees* begin on the participant or dependent's effective date. Pre-existing condition exclusion periods (and accompanying 6-month look-back periods) for *new hires* will begin on the date the participant enters a class eligible for coverage.

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## BENEFIT MANAGEMENT PROVISIONS

To ensure that cost-effective services are provided, the utilization review company places responsibility for benefit management with physicians, as they control health care utilization. When benefit management procedures are not followed, the result will be a reduction in payment to contracting providers for **which** the patient is not liable.

### PRIOR APPROVAL

Prior approval is required prior to the participant receiving certain services, supplies, or procedures. The participant or the health care provider must request Prior Approval from the Benefit Services Administrator.

Prior approval does not guarantee benefits under this Plan. The approved services will be subject to all applicable limitations and exclusions of this Plan, including the participant's eligibility to receive benefits. If prior approval is denied, the participant will receive written notice in which the reason(s) for denial will be listed. The notice will be mailed to the most current address we have on record for the participant and his or her health care provider.

Please refer to the Schedule of Benefits for services requiring prior approval.

### UTILIZATION REVIEW

Planned inpatient stays must be pre-certified to the Utilization Review Company prior to the actual admission. Unplanned admissions must also be pre-certified within two business days following the date of admission to the Utilization Review Company. Observation exceeding 23 hours will be considered an inpatient admission and must be reviewed. Each hospital, rehabilitation or nursing facility stay, planned or unplanned, requires Utilization Review.

Utilization Review is not required for hospital admissions for childbirth if the length of stay for the mother and newborn child does not exceed 48 hours following a normal vaginal delivery, or 96 hours following a cesarean section. Utilization Review is required for maternity stays that exceed 48 hours for a vaginal delivery or 96 hours for cesarean delivery.

Their phone lines are available 24 hours per day, every day of the year. The utilization review coordinator can be reached at:

**Nationwide ..... 1-800-782-9955**

If services are determined to be not medically necessary or not covered by this Plan, benefits will be denied.

### Pre-admission certification

Pre-admission certification is required prior to the participant receiving certain services. The participant or the health care provider must request pre-admission certification from the Utilization Review Company.

Certain factors may alter or impact whether the participant receives approval. These factors include benefit limitations, continued Plan participation, and the date he or she receives services.

### SelectFirst™ and Non-SelectFirst™ Providers

All scheduled inpatient admissions must be reviewed by the Utilization Review Company before hospitalization occurs. It is the SelectFirst™ provider's responsibility to obtain this pre-admission certification for all scheduled hospitalizations.

If a participant obtains services from a non-SelectFirst™ provider, it is the responsibility of the patient to obtain Utilization Review prior to the hospital admission. The participant will be responsible for any penalty for failure to obtain Utilization Review.

**When the participant receives care from a SelectFirst™ Care provider, the provider will handle the pre-admission certification for the participant. If a penalty for failure to comply is involved, the participant is not responsible. However, if the participant seeks care from a non-SelectFirst™ provider, he or she is responsible for compliance with the Utilization Review Provisions as described in the following sections, and any penalties (See *Penalty for Non-Compliance*) incurred will be the participant's responsibility.**

Please refer to the Schedule of Benefits for services requiring pre-admission certification.

### Prospective Reviews

The Utilization Review Company will respond to the pre-admission request within 15 days of the request. The 15-day decision period may be extended one time, up to an additional 15 days if

more time is needed to make the determination due to reasons beyond the Utilization Review Company's control.

The provider or participant will be notified prior to the expiration of the 15-day period of the circumstances requiring an extension of time and the date by which a decision can be rendered. If the extension is necessary because additional information is needed from the provider or participant, the notice will specifically describe the information needed and the provider or participant will have 45 days from receipt of the notice to provide the information.

If a request is received that does not meet the filing procedures, the covered person or their authorized representative will be notified within 5 days of the proper procedures to be followed in obtaining a Utilization Review. Notification will be provided by telephone or if requested, in writing.

### **Urgent Care Reviews**

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In the case of urgent care for the participant or a covered member of the participant's family, the provider or a family member must telephone the Utilization Review Company within 48 hours of urgent care or on the first business day following weekend or holiday care.

The Utilization Review Company will respond to the participant's urgent care request within 24 hours of his or her telephone call. The determination will be provided orally unless written notification is requested.

If additional information is needed to make a determination, the participant or provider will be notified within 24 hours of the specific information needed. A determination will be made within 48 hours of receipt of the requested additional information. If the additional information is not received within 48 hours, the request may be denied.

### **Retrospective Reviews**

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If the Utilization Review Company reviews medical treatment or services after the participant have received them, a decision will be made within a reasonable period of time, but no later than 30 days after the participant's request is received.

The Utilization Review Company may extend this 30-day period, only once, up to an additional 15 days if:

1. It is determined that an extension is necessary due to matters beyond their control; and
2. The participant is notified prior to the expiration of the initial 30-day period.

The participant will be informed of the circumstances requiring the extension and the date by which a determination can be rendered. If the extension is required because the participant failed to provide all the information necessary to reach a determination, the notice of extension will describe the required information still needed to complete the request. The participant will be given at 45 days from the day the participant receives his or her request to provide the information.

### **Concurrent Reviews**

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The Utilization Review Company will monitor all hospital stays by being in contact with the physician until the patient is discharged from the hospital. This service is automatically provided to all patients who have been certified under the pre-admission Utilization Review Program.

If a request to extend treatment beyond the initial period of time is received within 24 hours prior to the expiration of the certified period of time, the Utilization Review Company will respond to the provider's or participant request within 24 hours of the request. Treatment shall continue, without penalty, until the covered person is notified of the determination. If ongoing treatment benefits are reduced or terminated before the end of such treatment, the participant will be notified sufficiently in advance to give ample time to appeal the decision before the reduction or termination goes into effect.

### **Counting Time Periods**

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Under prospective and retrospective reviews, time periods are counted starting on the day the Utilization Review Company receives the pre-certification request. If the review periods are extended either 15 or 30 days, respectively, because the provider or participant failed to provide the appropriate information, the time period within which the Utilization Review Company is required to complete their review is suspended until the earlier of: when the Utilization Review Company receives the additional information from the provider or participant; or the 45-day time period the Utilization Review Company allotted the provider or participant to submit the requested information has expired.

If the provider or participant fails to submit the requested information, the Utilization Review Company may deny the request for approval of a medical treatment or service.

## PHYSICIAN REVIEW

Nurse reviewers certify the majority of inpatient stays, but if the participant's condition or treatment plan does not satisfy certain criteria, consultation begins with a physician reviewer. The selection of a physician reviewer depends on the patient's diagnosis and the procedures that have been or will be involved in the course of treatment. The physician selected will represent a medical specialty which is directly related to the patient's condition.

The attending physicians' name(s) will be shared with the physician reviewer after a decision is made. Then the attending physician is encouraged to talk with the physician reviewer about any questions or concerns regarding the decision.

In the event of a denial or reduction of benefits, the participant (or his/her authorized representative), the attending physician and the hospital are notified immediately.

## DISCHARGE PLANNING

Discharge planning begins the day of admission. The purpose of this provision is to ensure maximum coordination among the family, health care provider and utilization review staff in the event discharge to alternative care is warranted. Every effort is made throughout each stay to maintain patient care in the most cost-effective setting while not sacrificing the quality of care.

## PENALTY FOR NON-COMPLIANCE

All eligible charges requiring prior approval or pre-admission certification may be reduced by 20% up to a maximum of \$150 for any single hospitalization if the participant fails to comply with the requirements of the Benefit Management Provisions.

**This penalty will be waived for maternity stays with a duration of 48 hours for a normal vaginal delivery, or 96 hours for a cesarean section. Penalties may be applied to maternity stays which exceed these guidelines.**

## CASE MANAGEMENT

Case management is a program designed to assist the participant with a potentially long-term, high-cost or catastrophic illness and/or injury. The objective is to offer alternatives to traditional care settings. Health care benefits are tailored to meet medical needs while promoting quality and cost-effective outcomes. Case management administration is performed on a case-by-case basis. Benefits may include supplies or services which are not normally a covered benefit under this Plan. Case management's goal is to return people to productive lives after a catastrophic illness or injury whenever possible.

Examples of the types of conditions requiring an evaluation are AIDS, brain tumors, cancer, gastrointestinal conditions, head and spinal cord injuries, severe burns and/or strokes.

### Alternate Treatment Under Case Management

In cases where a participant's condition is expected to be or is of a serious nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified to perform such services. The Plan Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of the patient's care.

## EXTERNAL REVIEW

If the participant has exhausted our appeal process regarding a denial of benefits based on medical necessity, the participant or his or her health care provider, acting on the participant's behalf, may be entitled to request an external review of our decision through the South Dakota Division of Insurance.

South Dakota Division of Insurance  
445 E. Capitol Ave.  
Pierre, South Dakota 57501-2000  
Telephone: 1-605-773-3563

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# HOW THE MEDICAL PLAN WORKS

## DESCRIPTION OF MEDICAL BENEFITS

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### Individual Deductible

Each participant, unless otherwise specified, will be responsible for the individual calendar year deductible amount specified in the Schedule of Benefits before any medical benefits will be paid by this Plan.

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### Family Deductible

If the employee elects to take family coverage, the total deductible the employee and his/her covered dependents have to pay in a calendar year will never be more than the family deductible amount specified in the Schedule of Benefits; each participant's responsibility will be limited to the individual deductible amount specified in the Schedule of Benefits. The family deductible is the same regardless of the number of the employee's dependents.

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### Common Accident Deductible

If two or more family members are injured in the same accident, only one deductible will be applied to all of the related charges.

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### Coinsurance

Once the participant has paid the calendar year deductible, this Plan will pay the coinsurance percentages of the covered medical expenses outlined in the Schedule of Benefits.

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### Out-of-Pocket Maximum

There are limits on how much the employee will have to pay per individual, or per family, in allowable medical expenses per calendar year. The Schedule of Benefits specifies what the out-of-pocket maximum includes and what it excludes. The out-of-pocket maximum never includes ineligible charges. Once the out-of-pocket maximum has been met, this Plan pays 100% of the allowable expenses.

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## WHAT ARE COVERED EXPENSES?

All services must be medically necessary. The Benefit Services Administrator determines what is medically necessary, however, if necessary, the Plan Administrator makes the final determination whether a service is medically necessary, and that decision is final and conclusive. This Plan may include benefits not normally considered medically necessary. These are specifically included as benefits on the following pages.

The fact that a physician or dentist may have prescribed, ordered, recommended, or approved the provision of certain services or supplies does not necessarily mean such services or supplies are medically necessary or make the service a covered expense.

### AMBULATORY/OUTPATIENT SURGERY

Outpatient surgeries can be performed either in the outpatient department of a hospital, an independent surgery center or in a physician's office. This benefit includes coverage for the facility charges of an "ambulatory surgery center". An ambulatory surgery center is any public or private establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing outpatient surgical procedures, with continuous physician services and registered professional nursing services whenever a patient is in the facility, and which does not provide services or other accommodations for patients to stay overnight.

### ANNUAL PHYSICAL EXAM

This Plan has been designed to encourage the participant to promote good health by providing benefits for certain preventive care.

An annual routine physical examination is a covered expense under this Plan for participants and covered dependents. Benefits include, but are not limited to, physician fees, related x-ray and laboratory fees, immunizations routine diagnostic colon exams, and well child care for children up to age two. The procedures do not need to take place at the same time.

This benefit does not include eye or dental examinations.

## DENTAL SERVICES COVERED UNDER MEDICAL BENEFITS

The following services, including those services billed by a dentist, are covered under the medical portion of this Plan;

- (a) jaw and natural teeth repair if due to, and incurred within three months after an accidental injury (excludes treatment for injuries associated with the act of mastication);
- (b) plastic reconstruction or repair of the mouth or lips to correct defects due to an accidental injury;
- (c) orthognathic surgery. Treatment must be for a functional problem; not a cosmetic problem;
- (d) surgical removal of impacted teeth as an outpatient (includes outpatient hospital or dentist's office);
- (e) inpatient surgical removal of impacted teeth if hospitalization is required because of a hazardous medical condition (e.g., hemophilia); and
- (f) treatment of temporomandibular joint syndrome (TMJ).

## DIAGNOSTIC X-RAY AND LABORATORY BENEFITS

Benefits are payable for outpatient diagnostic x-ray or laboratory services which are provided or recommended by a physician. They may be performed in the physician's office, the outpatient department of a hospital or in a free-standing diagnostic lab or x-ray center.

## HOME HEALTH CARE

Home health care benefits consist of the following medically necessary services for the treatment of an injury or illness when prescribed by a physician:

- (a) part-time nursing care provided in the home by a registered nurse (RN), a licensed practical nurse (LPN), or a licensed public health nurse (LPHN);
- (b) physical, occupational or speech therapy;
- (c) medical supplies, drugs and medications prescribed by a physician; and
- (d) laboratory services by or on behalf of a hospital.

Home health care benefits for each participant are limited as specified in the Schedule of Benefits.

Home health care benefits will not include any services performed by a member of the participant's immediate family or a person ordinarily residing in the participant's home. Home health care benefits do not include meals, personal convenience items or housekeeping services. No home health care services are payable for the treatment of a mental health or chemical dependency disorder.

## HOSPICE CARE BENEFITS

Hospice services are those which help terminally ill participants and their families continue life with minimal disruption of normal activities.

The decisions relating to patient care are shared by an interdisciplinary hospice care team. The team is responsible for assuring continuity of care and providing professional management of all services. The attending physician is considered a member of this team. The attending physician updates, reviews, and approves the care plan as often as appropriate to meet the changing needs of the hospice patient and his/her family. The physician remains the primary provider of medical care.

Services reimbursed by this Plan for hospice care must be necessary for the palliation or management of the terminal illness and related conditions. Services covered must be consistent with the plan of care of the hospice care team. All services must be prescribed by and under the supervision of the attending physician and approval from the Benefit Services Administrator should be obtained prior to commencement of hospice care.

The following types of hospice expenses are covered by this Plan:

- (a) room and board in a hospice facility, hospital (up to the hospital's semi-private room rate) or nursing facility (up to the nursing facility's semi-private room rate);
- (b) bereavement counseling;
- (c) part-time or intermittent nursing care by a registered nurse (RN) or licensed practical nurse (LPN);
- (d) other necessary services such as medical supplies, medicines, drugs, physician's services and the rental or purchase of durable medical equipment;

(e) physical and occupational therapy.

Some items **not** covered under hospice care are:

- (a) funeral arrangement;
- (b) pastoral counseling;
- (c) financial or legal counseling which includes estate planning or the drafting of a will;
- (d) homemaker or caretaker services which are not solely related to care of the participant, including sitter or companion services for either the participant who is ill or other members of the family;
- (e) transportation; and
- (f) housecleaning and maintenance of the house.

## HOSPITAL

Hospital benefits include the daily room and board charge for each day of confinement, up to the semi-private room rate for the level of care the patient is receiving. If the hospital does not have semi-private rooms, benefits will be paid at the lowest private room rate. Charges for special care units (e.g., isolation or intensive care rooms and operating rooms) are covered provided the level of care was prescribed by a physician and deemed to be medically necessary.

**Please note:** Observation exceeding 23 hours will be considered an inpatient admission and must be reviewed. See the Preadmission Certification criteria contained in the Benefit Management Provisions section of this Plan for proper direction in obtaining Utilization Review.

Payment will be made for hospital miscellaneous charges such as oxygen tents and surgical supplies during a period of confinement for which room and board benefits are payable.

Personal convenience items, including, but not limited to, televisions, telephones and admission kits are not payable expenses under this Plan.

## MATERNITY BENEFITS

Expenses incurred by all female participants of this Plan, as the result of pregnancy, will be covered in the same manner as services for any other illness. Benefits will be paid according to the Plan provision for the type of expense incurred, i.e., hospital expenses under the hospital expense benefit, obstetrical delivery under the surgical expense benefit, etc. Maternity Charges for all Physicians.

Office call charges for pregnancy are part of the obstetrical global fee. Maternity visits for routine pregnancy are only payable at the time of delivery.

This Plan is in compliance with The Newborns' and Mothers' Health Protection Act of 1996. This act specifies that if plans provide maternity benefits for mothers and newborns, those benefits must include a minimum 48 hour hospital confinement following a vaginal delivery or a minimum 96 hour hospital confinement following a cesarean delivery. Earlier discharges are permitted if the attending physician and the mother agree to an earlier discharge. Penalties cannot be applied if inpatient maternity stays that are within these time frames are not pre-certified. However, penalties may be applied to maternity stays that exceed these timeframes, if not pre-certified.

### **Inpatient Newborn Benefits**

Expenses incurred for care of a well newborn, including routine nursery room and board, routine inpatient physician visits and circumcision will be considered part of the mother's maternity expenses and will be paid as part of her claim until the newborn is discharged from the hospital.

If the baby is ill, suffers an injury, requires other than routine care, expenses incurred will be considered separate from the mother's maternity expenses and subject to all plan provisions (e.g., deductibles and out-of-pocket maximums) on the same basis as any other medical claim.

## **MENTAL HEALTH AND CHEMICAL DEPENDENCY**

This Plan provides benefits for the following mental health and chemical dependency related services. Benefits are subject to the limits shown on the Schedule of Benefits.

### **Hospital Inpatient Benefits**

Benefits include daily room and board charges up to the hospital's room rate. Unless otherwise excluded, this Plan will provide benefits for hospital miscellaneous charges such as therapy and supplies incurred during the time room and board benefits are payable.

### **Outpatient and Physician Office Benefits**

Unless otherwise excluded, this Plan will provide benefits for medically necessary services including partial hospitalization, therapy and

supplies provided in an outpatient or office setting.

### **Partial Hospitalization Benefits**

Partial hospitalization is a non-residential day or evening treatment program that may be hospital-based or free-standing. The program provides clinical diagnostic and treatment services at a level of intensity equal to an inpatient program, but on a less than 24-hour basis.

### **Residential Benefits**

Residential benefits include inpatient treatment for mental health and/or chemical dependency disorders. This benefit will pay for the daily room and board charges subject to the limits of this Plan. Unless otherwise excluded, this Plan will provide benefits for miscellaneous charges such as therapy and supplies incurred during the time room and board benefits are payable. Confinement in a residential treatment facility must be recommended by and under the supervision of a physician.

## **MORBID OBESITY**

Morbid obesity is a condition of persistent and uncontrollable weight gain that constitutes a present or potential threat to life.

Morbid obesity benefits are eligible if ALL of the following criteria have been met:

- (a) recommended by a physician with prior approval;
- (b) the participant's weight is more than 100% over standard weight for height, sex, and age;
- (c) the participant has been considered morbidly obese by a physician for at least five years; and
- (d) non-surgical methods of weight loss have been supervised by a physician for at least three years without success.

## **ORGAN AND/OR TISSUE TRANSPLANTS**

Benefits are payable for participant charges of transplant services. **Prior approval must be obtained prior to beginning any transplant services.**

Covered human-to-human transplants include the following procedures: heart; heart/lung; single lung; liver; kidney/pancreas; cornea; kidney; pancreas; bone marrow; and other transplant procedures which are considered non-

experimental or non-investigational as approved by this Plan.

Benefits include:

- (a) organ procurement which consists of removing, preserving and transporting the donated organ; and
- (b) transportation of the recipient and a companion to and from the site of the transplant. If the recipient is a minor, coverage will be provided for one individual to accompany the minor. Reasonable and necessary lodging and meal costs incurred by such companions are also covered.

If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefits will be paid for charges incurred for procurement and transportation as described above.

Some items **not** covered under transplant benefits are:

- (a) treatments, services or supplies that are educational or provide primarily for research;
- (b) any services or supplies related to transplants involving mechanical organs; and
- (c) expenses associated with the purchase of any organ.

## PHYSICIAN SERVICES

### Outpatient Services

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Outpatient services by a physician for treatment of an injury or illness are covered benefits of this Plan. Please refer to the Schedule of Benefits for specific limitations.

### In-Hospital Services

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In-hospital services by a physician for treatment of an injury or illness are covered benefits of this Plan. Only one visit per day per specialty will be considered an eligible expense, unless additional visits are deemed to be medically necessary.

This benefit also includes consultations by other physicians, if medically necessary and recommended by the attending physician. The consulting physician must be conferring in a medical specialty different than the specialty of the attending physician or any other consulting physician.

## SKILLED NURSING FACILITY

Benefits are provided for a nursing facility if the care is medically necessary to treat an injury or illness and is prescribed by a physician. Nursing facility benefits for each participant are limited as specified in the Schedule of Benefits. Services must be medically necessary and care cannot be of a custodial nature.

Nursing facilities are used by those who require rehabilitation or additional time to recover from an injury or illness but do not need the acute care provided in a hospital.

Payable charges for services include:

- (a) room, board and other services and supplies furnished by the home for necessary care (other than personal items and professional services;
- (b) special treatment rooms;
- (c) x-ray and laboratory examinations;
- (d) physical, occupational or speech therapy;
- (e) oxygen and other gas therapy; and
- (f) any other services customarily provided by a nursing facility. Room and board charges will be limited to the semi-private room rate for the level of care the patient is receiving in the nursing facility.

As with hospitalizations, successive periods of confinement due to the same or related causes are considered as one period of confinement, unless the subsequent confinement commences after complete recovery or, in the case of the employee, return to work.

## SUPPLEMENTAL ACCIDENT BENEFITS

This Plan will pay expenses specified below for treatment related to an accident:

- (a) for hospital room and board and necessary services and supplies;
- (b) for physician professional services;
- (c) for nursing care prescribed by the attending physician and provided by a registered nurse (RN). If a registered nurse (RN) is not available as certified by the attending physician, the services of a licensed practical nurse (LPN) will be covered for nursing duties. Charges for performing domestic tasks are not a benefit;
- (d) for drugs, medicines, and dressings which can only be obtained with a physician's

written prescription and dispensed only by a licensed pharmacist;

- (e) for braces, crutches, artificial limbs or artificial eyes, or for rental of a wheelchair, hospital-type bed, or an artificial respirator;
- (f) for diagnostic x-ray or laboratory examinations;
- (g) for local ground transportation to and from a hospital by a professional ambulance service; or
- (h) for treatment of a fractured jaw or treatment of injuries to natural teeth (including their replacement) by a dentist or a physician.

This benefit is intended to supplement the other medical benefits of this Plan and may not be used to satisfy the participant's deductible. Payments will only be made for expenses incurred within 90 days of the accident. Expenses not paid under this special provision will be considered for payment under the normal Plan provisions for the type of service involved.

## **SURGICAL**

Surgical benefits include professional fees for performing a covered surgical procedure to treat an injury or illness. Services may be provided on an inpatient or outpatient basis at a hospital or in a physician's office. Surgical benefits include:

- (a) surgical, operative and cutting procedures, and major endoscopic procedures;
- (b) treatment of fractures or dislocations or suturing of wounds;
- (c) cutting procedures for the treatment of oral diseases or extraction of impacted teeth;
- (d) medically necessary surgical assistance by a physician. Benefits are not provided if the assistant is an intern, resident, or member of the hospital staff or is compensated by the hospital. The surgical procedure and medical condition of the participant must require the services of a surgical assistant. Benefits are limited to the reduced rate of the surgical allowance;
- (e) administration of anesthesia in connection with a surgical procedure if the anesthetic is administered by a physician or certified registered nurse anesthetist (CRNA), other than the operating or assistant surgeon, the physician is not employed or compensated by the institution in which the surgery is

performed and the physician bills for the administration of the anesthetics

Compensation for usual pre-operative and post-operative care is included in the payment for surgical services.

This Plan is in compliance with the Women's Health and Cancer Rights Act of 1998 and, for individuals who choose breast reconstruction surgery, the Plan will allow benefits for 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 physical complications of all stages of mastectomy, including lymphedemas.

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## SELF-AUDIT BILLING CREDIT

The Plan offers an incentive credit to all participants to encourage examination and self-auditing of eligible medical bills to ensure the amounts billed by any provider of services accurately reflect the services and supplies received by the participant or covered dependent. The participant is voluntarily asked to review all hospital and doctor bills and verify that he/she has received each itemized service and the bill does not represent either an overcharge or a charge for services never received (regardless of the reason). The Plan Benefit Services Administrator agrees to assist the employee (at his/her request) in determination of errors, and recovery attempts.

In the event a participant's self-audit results in elimination or reduction of charges, 25% of the amount eliminated or reduced will be paid directly to the participant (subject to a \$10.00 minimum

savings), provided the savings are accurately documented, and satisfactory evidence of a reduction in charges is submitted to the Benefit Services Administrator (e.g., a copy of the incorrect bill and a copy of the corrected billing).

This self-audit credit is in addition to the payment of all other applicable plan benefits for legitimate medical expenses.

Participation in this self-auditing procedure is strictly voluntary; however, it is to the advantage of the plan as well as the plan participant, to avoid unnecessary payment of health care dollars and any subsequent remaining balance (the plan member's liability) on an incorrect billing.

This credit will not be payable for charges in excess of the maximum allowable fee, regardless of whether the charge is or is not reduced.

The minimum incentive credit paid to an employee will be \$2.50; the maximum incentive credit paid to an employee will be \$500.00 per calendar year.

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## OTHER COVERED MEDICAL CARE

- (1) **Allergy.** Allergy tests and injections.
- (2) **Ambulance.** Professional air or ground ambulance service to the nearest, local adequate hospital or nursing facility for medically necessary treatment of an injury or illness.
- (3) **Bereavement counseling.**
- (4) **Blood.** Blood (unreplaced), blood plasma and blood plasma expanders, and their administration.
- (5) **Chelation therapy.** Limited to the treatment of heavy metal poisoning.
- (6) **Chemotherapy.** Treatment for malignancy.
- (7) **Chiropractic.** Chiropractic services including manual, mechanical manipulation of the spinal column.
- (8) **Contraceptives.** Charges for injectable, implantable, and device contraceptives, including surgical removal of implantable and contraceptive devices. Oral contraceptives, nuvaring and patches are available through the Prescription Drug Benefit.
- (9) **Cosmetic services.** Cosmetic surgery or reconstructive surgery when necessary:
  - (a) by an accident or injury;
  - (b) for correction of congenital deformity for a dependent child when necessary to perform a normal body function; and
  - (c) for reconstructive surgery as necessary for the prompt treatment of a diseased condition.
- (10) **Diabetic.** Diabetic equipment, supplies, medication, and self-management training and education, including medical nutrition therapy, for treatment of persons diagnosed with diabetes.
- (11) **Dietary services.** Dietary services only for inpatient or when prescribed by a physician for treatment of Phenylketonuria (PKU)
- (12) **Durable medical and mechanical equipment.** Purchase or rental up to the purchase price for durable medical and mechanical equipment of which is medically necessary for the treatment of the patient, such as wheelchairs, hospital beds, and respirators (equipment that is not available for purchase will require continuous rental).
- (13) **Electrocardiograms.**
- (14) **Electroencephalograms.**
- (15) **Eyeglasses, contact lenses or intraocular lens.** Initial placement is medically necessary following a covered surgical procedure to the eye.
- (16) **Hearing aids.** When recommended by a physician, limited as stated in the Schedule of Benefits.
- (17) **Hemodialysis.** Hemodialysis or peritoneal dialysis when provided to a participant as an inpatient of a hospital or as an outpatient in a Medicare approved dialysis center.
- (18) **Hydrotherapy.**
  - (a) to restore bodily function from an illness or injury;
  - (b) must produce significant improvement in the participant's condition with a reasonable period of time; and
  - (c) must be performed by a Physician as defined.
- (19) **Massage therapy.** Massage therapy provided by a physician, required to have direct (one on one) patient contact.
- (20) **Medical supplies.** Supplies that are medically necessary, including, but not limited to, cervical collars, colostomy bag, ileostomy supplies, catheters, syringes, crutches, casts, splints and braces.
- (21) **Medically necessary.** Services and supplies that are deemed Medically Necessary.
- (22) **Occupational therapy.** Occupational therapy under the supervision of a physician. Occupational therapy supplies are not a covered benefit of this Plan.
- (23) **Orthopedic braces.**
- (24) **Oxygen.** Oxygen and equipment for its administration.
- (25) **Pathological services.**
- (26) **Physical therapy.** Physical therapy provided by a licensed physical therapist to improve body function. Physical therapy

must be in accord with a physician's exact orders as to type, frequency, and duration.

- (27) Prescription drugs.** Drugs and medications obtainable only with a physician's written prescription and dispensed only by a licensed pharmacist, which are listed in the *U.S. Pharmacopoeia* and approved by the United States Food and Drug Administration.
- (28) Physician's professional services.** Physician's professional services provided in a hospital's outpatient or emergency room facility, the physician's office, or the participant's home.
- (29) Private duty nursing.** Private duty nursing services of a registered nurse (RN) in or out of a hospital or a licensed practical nurse (LPN) in a hospital. Private duty nursing services are covered only to the extent that they are medically necessary and prescribed by a physician. Payment is not made for services which are custodial.
- (30) Prosthetics.** Prosthetic appliances used to aid in the function of or to replace a missing natural part of the body or to improve, aid, or increase the performance of a natural function.

- (31) Radiation therapy.**
- (32) Respiratory therapy.**
- (33) Temporomandibular Joint Dysfunction (TMJ) and Orthognathic surgery.**
- (34) Self-inflicted.** Charges for suicide or treatment of any intentionally self-inflicted injury. This exclusion does not apply if the injury resulted from a medical or mental condition.
- (35) Speech therapy.** Limited to restore speech abilities lost due to illness or injury.
- (36) Sterilization.** Elective sterilization for the employee or dependent spouse.
- (37) Well-Child Care.** Charges for well-child care, including the usual, ordinary, and routine care of a newborn up to age two.
- (38) Wigs.** Wig for hair loss due to administration of cytotoxic agents, as limited in the Schedule of benefits.

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## MEDICAL EXCLUSIONS

- (1) **Abortion.** Abortion procedures for the termination of a pregnancy.
- (2) **Acupuncture.** Charges for acupuncture or acupressure therapy.
- (3) **Benefit maximum.** Any charges which exceed the benefit maximum.
- (4) **Biofeedback.** Charges for biofeedback or any goal oriented or behavior modification therapy.
- (5) **Blood.** Charges for autologous blood handling and storage.
- (6) **Corrective footwear.** Orthopedic shoes or corrective footwear devise not specifically designed or molded.
- (7) **Cosmetic.** Cosmetic services and/or supplies provided for cosmetic reasons intended to improve appearance or perception that are not deemed to be medically necessary.
- (8) **Court ordered.** Any court ordered rehabilitative treatment, service or supply.
- (9) **Custodial care.** Charges for custodial care, domiciliary care, or rest cures that assist in meeting daily living activities not requiring the continued attention and assistance of licensed medical or trained paramedical personnel. Such care includes, but is not limited to, assistance in walking, getting out of bed, aide in bathing, dressing, feeding, and supervision of medication which can be self administered.
- (10) **Dental implants.**
- (11) **Discounts.** PPO discount amounts "cash discounts", and sales tax. Surcharges and/or taxes for reimbursement of uncompensated care costs or other taxes imposed by a governmental body are eligible expenses under this plan.
- (12) **Educational or vocational training.** Services and supplies for recreational therapy, vocational training, and educational therapy (except diabetic education), including forms of nonmedical self-help or self-cure.
- (13) **Excess Charges.** The portion of a charge for services and supplies in excess of the maximum allowable fee.
- (14) **Exercise.** Charges for exercise equipment or health club memberships.
- (15) **Experimental or investigational.** Expenses in connection with services or supplies considered "experimental" or "investigational" as defined.
- (16) **Failure to keep appointments.** Charges for failure to keep scheduled appointments.
- (17) **Felonious acts.** Charges resulting from or caused during the commission of a felony.
- (18) **Food.** Food, nutritional supplements, or special diets and liquids unless provided while the covered participant is confined in the hospital.
- (19) **Foot care.** Charges for services in connection with corns, calluses or toenails.
- (20) **Foreign medical care.** Costs of drugs, procedures, services, supplies or treatment rendered or received in person, by mail or otherwise outside the United States if the purpose of such travel or communication is to obtain or receive such service, supply or treatment.
- (21) **Government service.** Any confinement, treatment, service or supply covered by a government program or law unless there is a legal obligation to pay for such treatment or service in the absence of coverage under this Plan.
- (22) **Hearing exams.**
- (23) **Hypnotism.**
- (24) **Illegal use.** Illegal use of narcotics or use of hallucinogens in any form, unless prescribed by a physician.
- (25) **Infertility.** Any charges related to any male or female fertility procedures, services, or supplies, including the diagnosis and/or treatment of infertility.
- (26) **Liposuction.**
- (27) **Mailing expenses.** Mailing and/or shipping costs.
- (28) **Marital counseling.**
- (29) **Massage therapy.** Massage therapy performed by a massage therapist.
- (30) **Medical information.** Charges for completion of claim forms or providing medical information necessary to determine coverage.
- (31) **No physician recommendation.** Care, treatment, services or supplies not recommended and approved by a physician.

- (32) **Nonprescription items.** Drugs or medicines that are available without a physician's prescription, even if prescribed or administered by a physician.
- (33) **Not medically necessary.** Any confinement, treatment, service, or supply if not recommended and approved by a physician or deemed not medically necessary for the condition of the participant, or any surgery or other type of medical treatment performed on an elective, non-medically necessary basis unless otherwise specified as covered by this Plan.
- (34) **No obligation to pay.** Charges for which the participant would not be responsible in the absence of this Plan.
- (35) **Obesity.** Charges for the treatment of obesity, weight control or diet, except morbid obesity.
- (36) **Occupational.** Charges for or in connection with any injury or illness arising out of or in the course of any occupational activity wherein the participant is required, by state law, to be covered by worker's compensation insurance.
- (37) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
- (38) **Relative giving services.** Services provided by a family member, whether relationship is by blood or law, or by any person who regularly resides in the participant's home.
- (39) **Riot.** Voluntary or active participation in a riot or other violent disorder, other than being present at the scene of such riot or disorder while performing his or her duties as an employee or governmental official, or in protecting the participant's life or property or the life or property of others.
- (40) **Routine care.** Routine services such as ,but not limited to, routine physical exams, premarital exams, pediatric care, urinalysis, exams and pregnancy tests, except as stated in this Plan.
- (41) **Sales tax.**
- (42) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred prior to the effective date of coverage, or after the termination date of coverage under this Plan.
- (43) **Sex change.** Care, services or treatment for non-congenital transsexuals, gender dysphoria, or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, and medical or psychiatric treatment.
- (44) **Smoking cessation.** Charges for the treatment of nicotine use or addiction.
- (45) **Sterilization reversal.**
- (46) **Telephone consultations.**
- (47) **Travel.** Charges for travel and accommodations, whether or not recommended by a physician.
- (48) **Third party liability.** Any charges for which a third party is liable, unless the participant who experiences such loss has agreed, in writing, to fulfill his obligations stated within this Plan.
- (49) **Vision.** Eyeglasses, contact lenses, eye refractions, vision therapy or surgery to correct eye refractions (including but not limited to radial keratotomy and keratomileusis). An exception to this exclusion is the medically necessary initial placement of a pair of eyeglasses or contact lenses following a covered surgical procedure to the eye.
- (50) **War.** Any loss that is due to a declared or undeclared act of war.
- (51) **Workers' Compensation.** Charges for or which the participant is entitled to benefits under Workers' Compensation law or any similar legislation.

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## **PRESCRIPTION CARD SERVICE BENEFITS**

**P**rescription drug benefits are administered through a program called Pharmaceutical Technologies Inc. (NPS). Under Federal Law, prescription drugs are only obtainable with a physician's prescription and must be dispensed by a licensed pharmacist.

### **RETAIL PRESCRIPTION DRUGS**

Prescription drugs can be purchased from any participating pharmacy. The Plan's benefit ID card must be presented to the pharmacist at the time of purchase. The pharmacy can require the participant to pay for the cost of the drug (less any applicable discount) at the time of purchase. Co-pays required at the time of purchase are as listed in the Schedule of Benefits. Generic drugs are mandatory unless the doctor requests dispense as written, i.e., the physician specifically requests a brand-name drug. If the participant or physician specifically requests a brand name drug when a generic is available, he/she will be responsible for the cost difference between the brand drug and the generic drug in addition to the copay. Participants are limited to a 34-day supply or a 100 unit dose supply per co-pay.

When a prescription is purchased from a non-participating pharmacy, the participant will need to pay the full price and submit the receipt and a claim form to Pharmaceutical Technologies Inc. (NPS). Because discounts are available when purchases are made through a participating pharmacy, the participant may not receive full reimbursement for the purchase at a non-participating pharmacy.

Claim forms can be obtained by calling the Pharmaceutical Technologies Inc. (NPS) at 1-800-546-5677.

Prior authorization may be required on some drugs in order to ensure appropriate utilization of medication. To obtain prior authorization, the participant or the health care provider must request the prior authorization by contacting the Pharmacy Benefit Manager.

**Pharmaceutical Technologies Inc. (NPS)**  
**1-800-546-5677**  
**[www.pti-nps.com](http://www.pti-nps.com)**

The fact that a Physician has prescribed, ordered, recommended or approved a Prescription Drug, medication or supply does not in itself make it eligible for payment.

**Important Note: If the participant disagrees with a reduction in or denial of benefits, see the Claim Determination and Claim Review Procedure sections for information on how to file an appeal. These sections also outline the time frames in which the Plan must respond to the claim and/or appeal.**

### **MAIL ORDER PRESCRIPTION DRUGS**

This Plan includes a mail order drug benefit for the purchase of maintenance drugs. Maintenance drugs are those medications which the physician has prescribed to treat an ongoing condition such as high blood pressure, diabetes or heart condition.

The mail order drug program is administered by Pharmaceutical Technologies Inc. (NPS). The participant may obtain as much as a 90-day supply for maintenance medication. The participant is required to pay the generic/brand name prescription co-pay as shown in the Schedule of Benefits at the time of purchase.

To take advantage of this optional benefit, please call **1-800-546-5677** or visit their website at: **[www.pti-nps.com](http://www.pti-nps.com)**.

Please refer to the Schedule of Benefits for specific limitations.

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## OTHER FACTS ABOUT THE HEALTH PLAN

### ASSIGNMENT OF BENEFITS

#### In PPO Area

Because of a contractual agreement with SelectFirst<sup>TM</sup>, benefits will be automatically assigned to participating providers. This Plan will not honor assignment of benefits received for any non-participating physicians or facilities. These benefits will be sent directly to the participant. Providers who do not participate in this network will not have benefits directly assigned to them. It is the participant's responsibility to make full payment to a non-participating provider.

#### Out-of-Area

This Plan accepts all assignments of benefits to make direct payments to providers of benefits, including, but not limited to, physicians, hospitals, and nursing facilities.

#### In General

Unless applicable law otherwise requires, no amount payable at any time will be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind and any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any amount, whether presently or at a later date payable, will be void. This Plan will not be liable for, or subject to, the debts or liabilities of any person entitled to any amount payable under this Plan. If by reason of the bankruptcy or other event happening at any such time such amount would not be enjoyed by them, then the Plan Administrator in its sole discretion, may terminate their interest in any such amount and will hold or apply it to or for the benefit of the participant, their spouse, children or other dependents, or any of them, in such manner as the Plan Administrator may deem proper.

### FILING OF CLAIMS

#### SelectFirst<sup>TM</sup> Physician Billings

SelectFirst<sup>TM</sup> physicians agree to submit claims for all covered services provided to SelectFirst<sup>TM</sup> participants.

#### SelectFirst<sup>TM</sup> Participating Hospital Billings

Participating hospitals are required to submit billings for covered services provided to SelectFirst<sup>TM</sup> participants.

#### All Other Providers

Claims incurred prior to termination date by participants in District's withdrawing from the Trust must be filed within 12 months after the District's termination date or such claim will be denied. The provider may submit billing statements on the participant's behalf, but it is the participant's responsibility to make sure claims are filed within this time.

All claims must be mailed to:

First Administrators, Inc.  
P.O. Box 8150  
Rapid City, SD 57709-8150

#### In General

Each participant shall file with the Benefit Services Administrator any pertinent information concerning himself/herself as the Benefit Services Administrator (or the Plan Administrator) may specify, and in the manner and form as the Benefit Services Administrator (or the Plan Administrator) may specify or provide, and the participant will not have any rights or be entitled to any benefits or further benefits hereunder, as the case may be, unless the information requested is filed by him/her or on his/her behalf. Each participant claiming benefits under the Plan shall supply written proof that covered expenses were incurred or that the benefit is covered under this Plan. If the Benefit Services Administrator determines that a participant has not incurred a covered expense or that the benefit is not covered under this Plan, or if the participant fails to furnish the proof requested, no benefits or no further benefits will be payable to the participant.

### APPEALING A CLAIM

There may be an occasion when the participant does not agree with the decision to deny or reduce benefits. The participant may want to appeal the decision. The appeal process, summarized below, allows the participant or someone acting on his/her behalf to request a first level appeal, expedited appeal, standard review, or second level appeal/voluntary review of the decision.

For appeals involving a determination of a benefit provided under this Plan, including patient's eligibility to receive benefits, please send the appeal request to

First Administrators, Inc.  
PO Box 8150  
Rapid City, SD 57709-8150.

### **First Level Appeal**

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The participant has the right to a full and fair review in case of an adverse determination. An adverse determination is the denial, reduction, or termination of a benefit. Types of adverse determinations include, but are not limited to, determinations involving:

- (a) Medical necessity;
- (b) Appropriateness of service, including level or effectiveness of treatment;
- (c) Place of service;
- (d) Experimental or investigational treatment;
- (e) Contract limitation;
- (f) Eligibility for coverage; or
- (g) Concurrent review not involving an urgent care request.

The participant or his/her authorized representative may request a first level appeal by submitting a written grievance within 180 days after the date the participant was notified of an adverse determination.

For appeals involving a determination of a benefit provided under this Plan, including patient's eligibility to receive benefits, please contact:

First Administrators, Inc.  
Appeals/Compliance Department  
PO Box 8150  
Rapid City, SD 57709-8150  
Telephone Number: 1-605-343-2509

Within three working days of receiving the appeal request, the participant or their authorized representative will be sent a letter specifying the name of the person, address and phone number where the review will be conducted. The participant has a right to submit written comments, documents, records, and materials relating to the appeal as well as the right to receive, upon request and free of charge, copies of all relevant documentation used to make the initial determination.

The appeal will be conducted by someone not previously involved in the case and not by a

subordinate of anyone previously involved. Appeals involving medical judgment will be reviewed by an appropriate medical expert. Only board-certified physicians will be consulted. The review will consider all pertinent documents, medical records, and additional information, regardless of whether the information was considered in the original decision, and will be independent of the original decision.

For first level appeals regarding a post-service issue, the participant or his/her authorized representative will be notified of the decision within 60 days after receipt of the grievance. For first level appeals regarding pre-service issues, the participant or his/her authorized representative will be notified of the decision within 30 days after receipt of the grievance. The decision of a first level appeal is subject to a second level appeal/voluntary review as outlined below.

### **Expedited Review**

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If the first level appeal involves a medically urgent situation or concurrent review urgent care request, participant or his/her authorized representative may request an expedited review. An expedited review focuses on adverse determinations regarding imminent or ongoing services. Expedited review requests may be submitted by telephone or in writing (including facsimile). Written expedited review decisions are provided within 72 hours of receiving information required for an expedited review. A medically urgent situation is one involving a type of service where a delayed response could seriously jeopardize the life or health of the covered person seeking services or would subject the covered person to severe pain that cannot be managed without the service in question, or is medically urgent in the opinion of a physician with knowledge of the person's medical condition.

Requests for an expedited review must be submitted within 48 hours of an adverse determination. In the event the basis of the request for an expedited review is termination of benefits, the participant's benefits will continue without liability in accordance with the terms of his/her eligible benefits until the participant is notified of the expedited review decision. If the expedited review decision results in the termination of benefits, the participant's benefits will end at 11:59 p.m., standard time, on the termination date stated on the notification of termination of benefits.

For appeals involving a determination of a benefit provided under this Plan, including patient's eligibility to receive benefits, please contact:

First Administrators, Inc.  
Appeals/Compliance Department  
PO Box 8150  
Rapid City, SD 57709-8150  
Telephone Number: 1-605-343-2509

### **Standard Review**

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The participant also has the right to a full and fair review of a grievance not involving an adverse determination. This type of grievance may include, but is not limited to, issues involving:

- (a) Availability, delivery, or quality of health services; or
- (b) Claim processing or payment.

The participant or his/her authorized representative may request a standard review by submitting a written grievance within 180 days after the date they were notified of a decision not involving an adverse determination.

For appeals involving a determination of a benefit provided under this Plan, including patient's eligibility to receive benefits, please contact:

First Administrators, Inc.  
Appeals/Compliance Department  
PO Box 8150  
Rapid City, SD 57709-8150  
Telephone Number: 1-605-343-2509

Within three working days of receiving the standard review request, the participant or their authorized representative will be sent a letter specifying the name of unit, address and phone number where the review will be conducted. The participant has a right to submit written comments, documents, records, and materials relating to the appeal as well as the right to receive, upon request and free of charge, copies of all relevant documentation used to make the initial determination.

The appeal will be conducted by someone not previously involved in the participant's case and not by a subordinate of anyone previously involved. Appeals involving medical judgment will be reviewed by an appropriate medical expert. Only board-certified physicians will be consulted. The review will consider all pertinent documents, medical records, and additional information, regardless of whether the information was considered in the original decision, and will be independent of the original decision.

For first level appeals regarding a post-service issue, the participant or the participant's authorized representative will be notified of the decision within 60 days after receipt of the participant's grievance. For first level appeals regarding pre-service issues, the participant or the participant's authorized representative will be notified of the decision within 30 days after receipt of his or her grievance. The decision of a first level appeal is subject to a second level appeal/voluntary review as outlined below.

### **Second Level Appeal/Voluntary Review**

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If the participant is not satisfied with the resolution of a first level appeal or standard review, the participant or his or her authorized representative have the right to make an appeal to the review committee.

The participant or his or her authorized representative may request a second level appeal/voluntary review by submitting a written grievance within 60 days after the receipt of the first level appeal decision or standard review decision.

Participants send a written grievance for a second level appeal/voluntary review to:

For appeals involving a decision made by the participant's Utilization Review Company as outlined in the Benefit Management Provision section, please contact the Utilization Review Company.

For appeals involving a determination of a benefit provided under this Plan, including patient's eligibility to receive benefits, please contact:

First Administrators, Inc.  
Appeals/Compliance Department  
PO Box 8150  
Rapid City, SD 57709-8150  
Telephone Number: 1-605-399-7300

Upon receiving the participant's request for a second level appeal/voluntary review the participant will be sent a letter notifying him or her of the date of the review committee meeting. In addition, the participant will also be advised of his or her rights to:

- (a) Make a request within five working days of the receipt of the letter, to appear in person (or by conference call) before a review committee;

- (b) Submit written comments, documents, records, and other materials relating to the appeal to the review committee;
- (c) Receive, upon request and free of charge, copies of all relevant documentation used during the appeal;
- (d) Present the case to the review committee;
- (e) Ask questions of any representative on the review committee; and
- (f) Be assisted or represented by an individual of the participant or the participant's authorized representative's choice.

The review committee will convene within 45 days of receiving the participant's request for second level appeal/voluntary review. The review committee consists of three individuals who were not previously involved in the participant's case.

The review committee will issue a final decision and notify the participant by letter within five working days after its meeting.

If the participant or his or her authorized representative does not request the opportunity to appear in person before the review committee, the review committee will issue a decision within 45 days of the participant's notice not to appear or within 45 days after the participant's opportunity to request a personal appearance expires, whichever is earlier.

The participant may contact the South Dakota Division of Insurance at any time for assistance with the appeal process at:

South Dakota Division of Insurance  
 445 E. Capitol Avenue  
 Pierre, SD 57501-3563  
 Telephone: 1-605-773-3563

## COORDINATION OF BENEFITS

Coordination of benefits (COB) refers to a process that is utilized when the participant has other insurance or coverage that provides the same or similar benefits as this Plan. The benefits payable under this Plan, when combined with the benefits paid under the participant's other coverage, will not be more than 100% of either our payment arrangement amount or the other carrier's payment arrangement amount.

This Plan, utilizing its normal benefit calculation method, will determine the amount to be paid and then subtract the payment(s) made by plans determined to be primary. The sum of all payments will never exceed the actual charge.

When the participant receives services, he/she needs to let us know that they have other coverage. Other coverage includes: group insurance; other group benefit plans (e.g., HMOs, PPOs, and self-insured programs); Medicare or other governmental benefits; and the medical benefits coverage in the participant's automobile insurance (whether issued on a fault or no fault basis). To help us coordinate the benefits, the participant should:

- (a) Inform the provider by giving him/her information about his/her other coverage at the time the participant receives services. The participant's provider will pass the information on to us when the claim is filed.
- (b) Indicate that the participant has other coverage when he/she fills out a claim form by completing the appropriate boxes on the form. The participant will receive a letter from us if we need any additional information.

It is important that the participant provide us with the requested information concerning his/her other coverage. If the participant does not give us the necessary information, his/her claims will be denied.

The following guidelines will be used to determine which plan will be primary:

- (a) If one plan has a COB provision and the other does not, the plan without a COB clause will be primary.
- (b) The medical benefits of the participant's auto coverage will pay before this plan if the auto coverage does not contain a coordination of benefits provision that specifies it is secondary or excess to health insurance or health benefit plans.
- (c) If both plans have a COB clause, the plan covering the participant as an employee will be primary over the plan covering the participant as a dependent.
- (d) If the participant is the main person covered under both plans (the participant is not a dependent under either plan), the plan that has provided coverage the longest will be primary.
- (e) The plan covering the participant as an active participant will pay before the plan covering the participant as an inactive participant. Participants in retiree plans, COBRA or other similar continuation coverage are considered inactive participants.

- (f) For a dependent child, the primary plan is the plan of the parent whose birthday (excluding year of birth) occurs earlier in the calendar year. For example, if the father's birthday is June 1 and the mother's birthday is May 1, the mother's plan would be primary for the children.
- (g) If both parents have the same birth month and day, the plan which has been in effect longest would be primary.
- (h) When the parents of a dependent child are divorced or separated and the parent with custody has not remarried, that parent's plan is primary for the child. The plan of the parent without custody pays second. When the parent with custody has remarried, that parent's plan is primary, the stepparent's plan is secondary and the plan of the parent without custody will be coverage of last resort. If there is a court decree which stipulates which parent has financial responsibility for the medical bills for the dependent child, the benefits of that parent's plan will be determined before the benefits of any other plans which cover the child as a dependent.
- (i) If none of the guidelines listed above apply, the plan which has covered the participant the longest will be primary.

### **Special Rules for SelectFirst™ Providers**

If this Plan is the secondary payer, and the provider is a SelectFirst™ participating provider, the billed charges will be subject to the SelectFirst™ fee schedule or discount. This Plan's payments as secondary payer, combined with the primary payer's payment, will never exceed the allowable payment according to the SelectFirst™ fee schedule or discount arrangement.

### **MEDICARE AS SECONDARY PAYER**

Since 1980, Congress has passed legislation making Medicare the secondary payer and group health plans the primary payer in a variety of situations. These laws apply only if the participant has both Medicare and Black Hills Educational Benefits Cooperative health coverage under this Plan and Black Hills Educational Benefits Cooperative has the minimum required number of employees as described in the following paragraphs.

### **Working Aged**

This provision applies only to group health plans of employers with at least 20 employees for each working day for at least 20 calendar weeks in the current or preceding year. Under this provision, Medicare is the secondary payer if the beneficiary is both of the following:

- (a) Age 65 or older.
- (b) A current employee or spouse of a current employee covered by an employer group health plan.

### **Working Disabled**

This provision applies only to group health plans of employers that had at least 100 full-time, part-time, or leased employees on at least 50% of the regular business days during the preceding calendar year. Under this provision, Medicare is the secondary payer if the beneficiary is all of the following:

- (a) Under age 65.
- (b) A recipient of Medicare disability benefits.
- (c) A current employee, or a spouse or dependent of a current employee, covered by an employer group health plan.

### **End-Stage Renal Disease (ESRD)**

The ESRD requirements apply to group health plans of all employers, regardless of the number of employees. Under these provisions, Medicare is the secondary payer during the first 30 months of Medicare coverage if both of the following are true:

- (a) The beneficiary has Medicare coverage as an ESRD patient.
- (b) The beneficiary is covered by an employer group health plan.

If the beneficiary is already covered by Medicare due to age or disability and becomes eligible for Medicare ESRD coverage, Medicare generally is the secondary payer during the first 30 months of ESRD eligibility. However, if the group health plan is secondary to Medicare (based on other Medicare secondary payer requirements) at the time the beneficiary becomes covered for ESRD, the group plan remains secondary to Medicare.

The above provisions are a general summary of the laws, which may change from time to time. For more information, contact the participant's employer or the Social Security Administration.

## **MEDICARE AS PRIMARY PAYER**

When the foregoing subsection "Medicare as Secondary Payer" does not apply, benefits otherwise payable under this Plan for allowable expenses shall be reduced so that the sum of benefits payable under this Plan and Medicare shall not exceed the total of such allowable expense.

Benefits shall be payable under this Plan after Medicare benefits have been paid whether or not such participant is disabled and not in an active employment status and under or over age 65, other than as specified for an ESRD beneficiary in the foregoing subsection.

Benefits shall be considered payable by Medicare for purposes of this section when the participant is eligible for Medicare benefits.

Benefits could be reduced if the participant:

- (a) has not enrolled or applied for benefits under Medicare;
- (b) has failed to take any action required by Medicare to qualify for benefits; or
- (c) received benefits payable by Medicare if services were received in a facility to which Medicare would have paid.

In the event a participant enters into a private contract with a Physician in accordance with Medicare private contracting arrangements, this Plan shall not coordinate benefits or assume a primary payer position on any such participant.

## **RELEASE OF INFORMATION**

The Benefit Services Administrator may, without notice to or consent of the covered person, release to or obtain from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Benefit Services Administrator, at its sole discretion, considers necessary to apply the provisions of this Plan.

## **RIGHT OF RECOVERY**

Whenever benefits have been paid in excess of the minimum amount necessary to satisfy the intent of the Coordination of Benefits provision, the Plan Administrator will have the right to recover those payments to the extent of the excess amount from any one or more of the following as the Plan Administrator determines:

- (a) any persons to whom such payments were made; or
- (b) any insurance companies or any other organizations.

The Plan Administrator will also have the right to cause the payment of any amounts it determines to be warranted to satisfy the intent of the Coordination of Benefits provision of this Plan to any organizations making payments under other plans which should have been made under this Plan.

## **THIRD PARTY REIMBURSEMENT**

If benefits have been paid or are payable under this Plan for services received by a participant, and it is later established that the charges for these services were not paid or are not payable by the participant or that the participant was otherwise reimbursed or may be reimbursed, except by insurers of policies of health insurance issued to the participant as an individual, this Plan will be entitled to a refund of the amount of the benefits paid which are in excess of the benefits that would have been payable based on the actual charges incurred and paid.

## **SUBROGATION**

### **Payment Condition**

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The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of a participant, Plan beneficiary, and/or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "participant(s)") or a third party, where another party may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

A participant, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources

in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Participant agrees the Plan shall have an equitable lien on any funds received by the participant and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The participant agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a participant settles, recovers, or is reimbursed by any Coverage, the participant agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the participant. If the participant fails to reimburse the Plan out of any judgment or settlement received, the participant will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

### **Subrogation**

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As a condition to participating in and receiving benefits under this Plan, the participant agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the participant is entitled, regardless of how classified or characterized.

If a participant receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any participant may have against any Coverage and/or party causing the sickness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may in its own name or in the name of the participant, commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the participant fails to file a claim or pursue damages against:

- (a) the responsible party, its insurer, or any other source on behalf of that party;
- (b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (c) any policy of insurance from any insurance company or guarantor of a third party;

- (d) worker's compensation or other liability insurance company; or,
- (e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the participant authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the participant's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The participant assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

### **Right of Reimbursement**

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The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the participant is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the participant recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the participant, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any

separate written acknowledgment of these rights is required by the Plan and signed by the participant.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

### **Excess Insurance**

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If at the time of injury, sickness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

- (a) the responsible party, its insurer, or any other source on behalf of that party;
- (b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- (c) any policy of insurance from any insurance company or guarantor of a third party;
- (d) worker's compensation or other liability insurance company; or
- (e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

### **Separation of Funds**

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Benefits paid by the Plan, funds recovered by the participant, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the participant, such that the death of the participant, or filing of bankruptcy by the participant, will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

### **Wrongful Death**

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In the event that the participant dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

### **Obligations**

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It is the participant's obligation at all times, both prior to and after payment of medical benefits by the Plan:

- (a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- (b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
- (c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- (d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- (e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- (f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the participant and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the participant will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the participant.

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the participant's cooperation or adherence to these terms.

### **Offset**

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Failure by the participant and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan on behalf of the participant may be withheld until the participant satisfies his or her obligation.

## **Minor Status**

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In the event the participant is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

## **Language Interpretation**

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The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

## **Severability**

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In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

## **WORKERS' COMPENSATION**

This Plan is not meant to be a substitute for workers' compensation. Any benefits paid by this Plan which are determined to be the liability of any workers' compensation plan of benefits will be refunded to this Plan by the participant and/or his/her heirs or estate. Any participant hereby agrees to reimburse this Plan for any payments so made under this Plan out of any monies recovered from any workers' compensation plan as the result of judgment, settlement or

otherwise, and the participant does agree to take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the Plan Administrator may require to facilitate the enforcement of this Plan's rights and not to prejudice those rights. Any portion of any settlement that is agreed upon which is for future expenses will also be recoverable under this Plan, as those expenses occur.

## **OVERPAYMENT OF CLAIMS**

Each participant hereby authorizes the deduction of any excess benefit received or benefits which should not have been paid, from any present or future compensation payments.

## **CONFORMITY WITH LAW**

If any provision of this Plan is contrary to any law to which it is subject, or if a law relevant to this Plan is not specifically addressed within the contents of pertinent documents, such provision will be amended to satisfy the law's minimum requirement.

## **AUTHORIZED REPRESENTATIVE**

The participant may authorize another person to represent you and with whom he/she wants us to communicate regarding specific claims or an appeal. This authorization must be in writing, signed and dated by the participant, and include all the information required in our Authorized Representative form. This form is available from the participant's employer. In a medically urgent situation the participant's treating health care practitioner may act as his/her authorized representative without completion of the Authorized Representative form. An assignment of benefits, release of information, or other similar form that the participant may sign at the request of his/her health care provider does not make his/her provider an authorized representative. The participant can revoke the authorized representative at any time, and the participant can authorize only one person as his/her representative at a time.

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## DEFINITIONS

**"ACCIDENTAL INJURY"** means an injury, independent of disease or bodily infirmity of any other cause, which happens by chance.

**"ACTIVE DUTY"** means full-time duty in the active military service of the United States. Such term includes full-time training duty, annual training duty, and attendance, while in the active military service, at a school designated as a service school by law or by the Secretary of the military department concerned. Such term does not include full-time National Guard duty.

**"ACTIVELY AT WORK"** means the performance of all the duties that pertain to the participant's work at his/her normal place of employment, or any other location required by the employer.

**"ADOPTED CHILD(REN)"** means any child legally placed in an employee's home by an adoption agency who meets the eligibility requirements of this Plan, whether or not the adoption is final. Placement is defined as the assumption and retention of a legal obligation for total or partial support of a child in anticipation of adoption of such child.

**"ADVERSE BENEFIT DETERMINATION"** means a denial, reduction, or termination of a benefit.

**"ALLOWABLE EXPENSES"** mean the portion of an eligible expense actually payable by this Plan, after taking into account co-pay, deductible, and coinsurance amounts, any applicable benefit maximum or maximums, and any other limitation or exclusion provided for under this Plan. This calculation is based on the payment method utilized by this Plan.

**"ALTERNATE RECIPIENT"** means any child of a participant who is recognized under a Qualified Medical Child Support Order (QMCSO) as having a right to enrollment in this Plan with respect to such participant.

**"AMBULATORY/OUTPATIENT SURGERY FACILITY"** provides surgical services on an outpatient basis for patients who do not need to occupy an inpatient, acute care hospital bed.

**"AMENDMENT"** means a formal document that changes a provision of this Plan, duly signed by the authorized person or persons as designated by the company.

**"BENEFIT SERVICES ADMINISTRATOR"** means the person or group providing administrative services to the Plan Administrator in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it.

**"BOARD"** means the Board of Directors of the company.

**"BRAND NAME PRESCRIPTION DRUG"** means the pharmaceutical products manufactured and sold under the name assigned by the developer/manufacturer.

**"BUSINESS ASSOCIATE"** means a person or organization that performs a function or activity on behalf of a covered entity, but is not part of the covered entity's workforce. A business associate can also be a covered entity in its own right. (Also see Part II, 45 Code of Federal Regulations Part 160.103).

**"CALENDAR YEAR"** means the 12-month period commencing January 1 and ending the next following December 31.

**"CHEMICAL DEPENDENCY"** means any condition resulting from dependency on or abuse of a psychoactive substance as described in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition - Revised*, (DSM-IV-R), published by the American Psychiatric Association or subsequent revisions to DSM-IV-R.

**"CHILD(REN)"** means child(ren) of a covered employee including natural children, adopted children, stepchildren and foster children.

**"CLAIM"** means any request for a Plan benefit made by a claimant or a representative of a claimant that complies with the Plan's reasonable procedure for making benefit claims.

**"COINSURANCE"** means the percentage(s) of eligible expenses allocable to the participant and the employer after any applicable co-pays, calendar year deductibles, or non-compliance penalties have been applied.

**"COMMITTEE"** means the Health Care Committee of the company, as appointed by the Board from time to time.

**"COMMON ACCIDENT DEDUCTIBLE"** is a single deductible amount you are responsible for when two or more of your family members receive covered services for injuries suffered in the same accident.

**"CONTINGENCY OPERATION"** means designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force.

**"CO-PAY"** means the predetermined amount paid by the participant on a per item or per service basis.

**"COSMETIC SERVICES"** means treatment or surgical procedures intended to improve physical appearance, but which do not treat illness, restore, or materially improve a deficiency in normal physiological function. Cosmetic services performed to alleviate psychological distress are not covered by the Plan.

**"COVERED DENTAL EXPENSES"** mean expenses incurred which are dentally/medically necessary that are not specifically excluded from coverage elsewhere in this Plan.

**"COVERED EXPENSES"** means those expenses covered by this Plan, including the hospital, surgical, and medical care expenses described in this booklet. However, expenses are not covered if they are expressly excluded, are not medically necessary, are experimental or investigational in nature, or if they exceed the maximum amount considered by this Plan. See also the definitions of eligible expenses and allowable expenses.

**"COVERED SERVICEMEMBER"** means a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness. Also included is a veteran who is undergoing medical treatment, recuperation, or therapy, for a serious injury or illness and who was a member of the Armed Forces (including a member of the National Guard or Reserves) at any time during the period of five years preceding the date on which the veteran undergoes that medical treatment, recuperation, or therapy.

**"CREDITABLE COVERAGE"** means coverage under a group health plan (including a governmental or church plan), health insurance coverage (either group or individual insurance, including COBRA continuation coverage, or short-term "bridge" policy), Medicare, Medicaid, military-sponsored health care, a program of the Indian Health Service, a state health benefit risk pool, the Federal Employees Health Benefits Plan

(FEHBP), a public health plan as defined in subsequent Centers for Medicare and Medicaid Services regulations, state Children's Health Insurance Program (S-Chip), public health plans provided by a foreign country or a political subdivision and any health benefit plan under Peace Corps Act 5(e).

"Creditable Coverage" does **not** include accident or disability income, liability, workers' compensation, automobile medical insurance, health coverage for limited benefits, such as limited scope dental or vision benefits or long-term care plans, or plans under which health benefits are secondary or incidental.

**"CUSTODIAL CARE"** helps you with your daily living activities. This type of care does not require the continuing attention and assistance of licensed medical or trained paramedical personnel. Some examples of custodial care are assistance in walking and getting in and out of bed; aid in bathing, dressing, feeding and other forms of assistance with normal bodily functions, preparation of special diets; and supervision of medication which usually can be self-administered. Custodial care is not a benefit under this Plan.

**"DEDUCTIBLE"** is the amount for covered services you pay before this Plan begins paying benefits.

**"DENTAL IMPLANTS"** mean dental implants made of metal or other foreign material and placed into or on the alveolar bone to provide support.

**"DENTIST"** means a duly licensed Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) practicing within the scope of the dental profession and any other physician furnishing any dental services which such physician is licensed to perform.

**"DEPENDENT"** means the legal spouse of an employee or retiree and children of an employee or retiree.

**"DISABLED"** means the temporary inability of a covered employee to perform each and every regular duty pertaining to his/her occupation or employment for compensation or profit, or the temporary inability of a covered dependent to engage in the normal activities of a person in good health of like age and sex.

**"DOMICILIARY CARE"** means inpatient institutional care provided to the participant not because it is medically necessary, but because care in the home setting is not available, is

unsuitable, or members of the patient's family are unwilling to provide care. Institutionalization because of abandonment constitutes domiciliary care. Domiciliary care is not a benefit under this Plan. Some examples of domiciliary care for which benefits are not payable:

- (a) home care is not available, such as where institutionalization is primarily because parents work or where a hospital stay is extended beyond what is medically necessary because the patient lives alone;
- (b) home care is not suitable, such as where a child is institutionalized because a parent(s) is an alcoholic who is not responsible enough to care for the child or because someone in the home has a contagious disease; or
- (c) the family is unwilling to care for a person in the home, such as where a family does not want to handle a child who is difficult to manage.

**"DURABLE MEDICAL EQUIPMENT"** means medical equipment not otherwise excluded, which is designed for repeated use, is primarily and customarily used to serve a medical purpose, and is not useful to a person in the absence of an injury or illness. For the purpose of determining whether a piece of equipment constitutes durable medical equipment for coverage under this Plan, First Administrators, Inc. may consult the equipment list compiled from time to time for use in the administration of the Medicare program. Examples of durable medical equipment include, but are not limited to, wheelchairs, hospital beds, and respirators. Air conditioners, humidifiers, dehumidifiers, air purifiers, and other similar convenience items are not considered durable medical equipment.

**"EFFECTIVE DATE"** means the first day that benefits under this Plan would be in effect, after satisfaction of the waiting period, if applicable, and any other provisions or limitations contained herein.

**"ELECTIVE SURGICAL PROCEDURE"** means a non-emergency surgery that can be scheduled at any time without risking the patient's life or risking serious impairment to the patient's bodily functions.

**"ELIGIBLE EXPENSE"** means the portion of a covered expense which is considered for payment under this Plan. If the course or manner of treatment of a condition is expressly excluded by this Plan, is not medically necessary, is

experimental, investigational or otherwise regarded by the Plan Administrator to be ineffective treatment for the condition, or not included because of any reason described in the Plan, then the expense for the treatment is not eligible. See the definition of allowable expense for a description of how this Plan computes the portion of an eligible expense which it will pay.

**"EMERGENCY"** means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain that a prudent layperson, possessing an average knowledge of health and medicine, could reasonably expect absence of immediate medical attention to result in one of the following:

- (a) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy.
- (b) Serious impairment to bodily function; or
- (c) Serious dysfunction of any bodily organ or part.

**"EMPLOYEE"** means any individual who is employed by the company.

**"ENROLLMENT DATE"** means the first day of a participant's waiting period under this Plan (typically, the date the employee's employment begins). The enrollment date for a late enrollee, or anyone who enrolls during a special enrollment period, is the first day of coverage under this Plan.

**"EXPERIMENTAL OR INVESTIGATIONAL SERVICES OR SUPPLIES"** mean that one or more of the following is true:

- (a) the device, drug or medicine cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the device, drug or medicine is furnished;
- (b) the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review and approval, and furthermore, that the treating facility's Institutional Review Board is reviewing such drug, device, treatment or procedure as being experimental or investigational;

- (c) reliable evidence shows that the treatment, procedure, device, drug or medicine is the subject of ongoing phase I, II or III clinical trials or is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; and/or
- (d) reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, drug or medicine 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 the standard means of treatment or diagnosis.

Reliable evidence means only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same treatment, procedure, device, drug or medicine; or the written informed consent used by the treating facility or by another facility studying substantially the same treatment, procedure, device, drug or medicine.

In addition, no reimbursement is available for payments of any: (1) treatments, services or supplies that are educational or provided primarily for research; or (2) treatments, procedures, devices, drugs or medicines or other expense relating to transplants of nonhuman organs.

**"FEE SCHEDULE"** means a contractually specified amount payable for physician's services within the PPO or SelectFirst™ area.

**"FOSTER CHILD"** means any child legally placed in the participant's custody and for whom the participant is legally responsible to provide medical care.

**"FULL-TIME STUDENT"** means a covered dependent who meets the age requirements of this Plan, is enrolled in a full-time (as defined by the institution they are attending or at least 12 credit hours per semester or quarter) course of study in an approved institution of higher learning.

**"GENERIC PRESCRIPTION DRUGS"** means the pharmaceutical products manufactured and sold under their common chemical or non-proprietary name. The generic equivalent of a brand name drug must meet the same standards for safety, purity, strength, and effectiveness as

the brand name drug. Both have the identical chemical composition and therapeutic effect.

**"HIPAA"** means the Health Insurance Portability and Accountability Act, a Federal law that allows persons to qualify immediately for comparable health insurance coverage when they change their employment relationships. Title II, Subtitle F, of HIPAA gives Health and Human Services (HHS) the authority to mandate the use of standards for the electronic exchange of health care data; to specify what medical and administrative code sets should be used within those standards; to require the use of national identification systems for health care patients, providers, payers (or plans) and employers (or sponsors); and to specify the types of measures required to protect the security and privacy of personally identifiable health care information. (Also known as the Kennedy-Kassebaum Bill, the Kassebaum-Kennedy Bill, K2, or Public Law 104-191).

**"HOME HEALTH AGENCY"** is a Medicare approved association or organization which provides skilled nursing care in your home.

**"HOME HEALTH SERVICES"** are health care services performed in your home by a home health agency.

**"HOSPICE"** provides care (usually in the home) for patients who are terminally ill and have a life expectancy of six months or less. The Hospice must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), be Medicare approved, and/or be licensed by the state in which it operates.

**"HOSPICE SERVICES"** include home health care plus respite services.

**"HOSPITAL"** is an institution that primarily provides diagnostic and therapeutic services for surgical and medical diagnosis, treatment and care of injured or ill persons. The facility must be licensed as a hospital under applicable laws.

**"HOSPITAL CONFINEMENT"** means being registered for a minimum of 23 hours as a bed patient in a hospital, nursing facility or chemical dependency facility upon the recommendation of a physician or as a patient in a hospital because of a surgical operation or receiving emergency care in a hospital for an injury within 48 hours after the injury is received.

**"ILLNESS"** means any bodily disorder, bodily injury, disease or mental health condition including pregnancy and complications of pregnancy.

**"IMMEDIATE FAMILY"** means a participant's legal spouse, parents and or children.

**"IMMUNIZATION"** is an injection with a specific antigen to promote antibody formation to make you immune to a disease or less susceptible to a contagious disease.

**"INFERTILITY"** means the inability or diminished ability to produce offspring.

**"INJURY"** means a physical condition which is the result of an accident caused by an external force with respect to that participant, and which results in loss covered by this Plan; or a condition caused as the result of an incident which is precipitated by an act of unusual circumstances likely to result in unexpected consequences; the condition must be an instantaneous one, rather than one which continues, progresses or develops.

**"INPATIENT"** means being confined in a hospital or a nursing facility as a resident patient and subject to at least one day's room and board charges by the hospital, nursing facility or chemical dependency facility.

**"INTENSIVE CARE UNIT"** means a unit exclusively reserved for critically and seriously ill or injured patients requiring constant audiovisual observation as prescribed by the attending physician which provides room and board, specialized registered nurse (RN) and other nursing care, and special equipment or supplies immediately available on a stand-by basis segregated from the rest of the hospital's facilities.

**"LATE ENROLLEE"** means a participant or beneficiary who enrolls under this Plan other than during: (a) the first period in which the individual is eligible to enroll under this Plan; or (b) a special enrollment period.

**"LEGEND DRUGS"** mean those drugs classified within any of the five categories for drugs that come under the jurisdiction of the most recent Controlled Substance Act and which may only be dispensed by a licensed pharmacist upon the written prescription of a physician. Compounded medications of which at least one ingredient is classified as noted above shall be included.

**"LICENSED PRACTICAL NURSE"** means an individual who has received specialized nursing training and practical nursing experience and who is licensed to perform nursing services by the state in which he/she performs such services, other than one who ordinarily resides in the

participant's home or who is a member of the participant's immediate family.

**"LICENSED PUBLIC HEALTH NURSE"** means a professional nurse who has the right to use the title registered nurse (RN), other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family, and who has extended their study in the public health field.

**"LIFETIME"** means the period of time a person is actually a participant under this Plan, commencing with the original effective date, and is not intended to imply or suggest benefits beyond an individual's termination date or this Plan's termination date as herein specified.

**"LOCAL AIR AND GROUND AMBULANCE"** means medically necessary transportation to an appropriate inpatient or outpatient facility in the surrounding area where the ambulance transportation originated. To determine if the ambulance transportation is covered, this Plan considers if no other method of transportation is appropriate, that the services necessary to treat the injury or illness are not available in the hospital, nursing facility or chemical dependency facility in which the participant is an inpatient or outpatient and the point of destination is the nearest one with adequate and appropriate methods of care.

**"MAINTENANCE DRUG"** means the prescription drugs and medications which are prescribed to treat a chronic medical condition, such as hypertension, diabetes, and certain heart conditions.

**"MAXIMUM ALLOWABLE FEE"** means the lesser of:

- The fee that has been negotiated with the provider whether directly or through one or more intermediaries, or shared savings contracts for the services; or
- The fee established by comparing rates from one or more regional or national databases or schedules for the same or similar services from a geographic area; or
- The billed charge for Out of Network Facility services.

**"MEDICALLY NECESSARY"** means that a procedure, service or supply is all of the following:

- (a) appropriate and necessary for the diagnosis and treatment of your injury or illness;

- (b) consistent with professionally recognized standards of health care determined within the state in which you reside and given at the right time and in the right setting;
- (c) not more costly than alternative services that would be effective for diagnosis and treatment of your condition; and
- (d) enables the patient to make reasonable progress in treatment.

**"MEDICARE"** is the federal government's health insurance program established under Title XVIII of the Social Security Act for people age 65 and older and people of any age entitled to monthly disability benefits under the Social Security or Railroad Retirement Program. It is also available for those with chronic renal disease who require hemodialysis or kidney transplant.

**"MENTAL HEALTH DISORDER"** means any disorder classified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition-Revised* (DSM-IV-R), or subsequent revisions to DSM-IV-R, and includes behavioral or psychological conditions not attributable to a mental disorder that are the focus of professional attention or treatment, but only to the extent services for such conditions are otherwise considered to be benefits under this Plan.

**"NEXT OF KIN"** means the nearest blood relative of an individual.

**"NON-PPO PROVIDER"** means any health care provider who is not a contracted member of SelectFirst<sup>TM</sup>.

**"NON-RESIDENTIAL TREATMENT PROGRAM"** means a program established for the purpose of providing non-residential treatment of chemical dependency and approved as such by a state department or agency having authority over such programs.

**"NOTIFICATION OF DECISION"** means delivery or furnishing of information by the Plan to an individual regarding decision of the claim for benefits. Information is considered delivered or furnished as of the date it is mailed by or verbally provided by the Plan.

**"NURSING FACILITY"** provides continuous skilled nursing services as ordered and certified by your attending physician. A registered nurse (RN) must supervise services and supplies on a 24-hour basis. A nursing facility must also be licensed under the laws of the state in which it operates.

**"OUT-OF-POCKET MAXIMUM"** is a specified amount that you must pay for covered services, out of your pocket, in a calendar year. Your out-of-pocket maximum is satisfied as indicated on the Schedule of Benefits. Once you meet the out-of-pocket maximum, this Plan pays 100% of the allowable expenses.

**"OUTPATIENT"** means a participant who receives treatment at a hospital, clinic or dispensary or other medical care facility but is not confined to continuous 24 hour inpatient care.

**"PARTIAL HOSPITALIZATION"** means an outpatient program specifically designed for the diagnosis or active treatment of a serious mental disorder when there is a reasonable expectation for improvement or when it is necessary to maintain a patient's functional level and prevent relapse or full hospitalization.

**"PARTICIPANT"** means any covered employee and any covered dependent.

**"PHYSICIAN"** means a provider of medical services legally licensed to practice medicine and surgery or any other legally licensed practitioner of the healing arts rendering, within the scope of the individual's license, services which are covered under this program and for which benefits are required to be provided by law when rendered by such a practitioner. In no event will the term "physician" include a resident physician, intern, or other individual in training, or a member of the participant's family.

**"PLAN"** means this Black Hills Educational Healthcare Benefit Plan, as set forth herein, and as from time to time amended, which is administered by First Administrators, Inc., the Benefit Services Administrator.

**"PLAN ADMINISTRATOR"** means the person or persons appointed to administer this Plan, if any, otherwise, the company.

**"PLAN SPONSOR"** means an entity that sponsors a health plan. This can be an employer, a union or some other entity. (Also see Part II, 45 Code of Federal Regulations Part 164.501).

**"PLAN YEAR (Fiscal)"** means the 12-consecutive month period commencing on July 1 and ending on June 30, identified as the Plan's fiscal year for the keeping of its records.

**"POST-SERVICE CLAIM"** means any claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims for services already received by the participant.

**"PPO AREA"** means the area encompassing the contracted PPO providers.

**"PPO MEMBER" or "PPO PROVIDER"** means a contracted health care provider who is a member of a preferred provider organization utilized by this Plan.

**"PRE-EXISTING CONDITION"** means any limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the effective date of coverage, whether or not any medical advice, diagnosis, care or treatment was recommended or received before that day.

**"PREFERRED PROVIDER ORGANIZATION" or "PPO"** means an organization composed of a group of health care providers who have contracted to offer their services at a discount rate in accordance with the formal agreement between the company and the preferred provider organization.

**"PRESCRIPTION DRUG"** means covered legend drugs, medicines or medications prescribed by a physician and dispensed by a licensed pharmacist necessary to treat an injury or illness.

**"PRE-SERVICE CLAIM"** means any claim for a benefit under this Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

**"PRIVATE DUTY NURSING"** means continuous bedside nursing service, rendered by one nurse to one patient, either in a hospital, nursing facility, hospice facility or the patient's home, as opposed to general duty nursing, which renders services to a number of patients in an inpatient setting.

**"PROCUREMENT COSTS"** mean those charges for services associated with the procurement of a human organ for transplant, including, but not limited to, surgical removal of an organ from a living donor, pathology and radiology services and services necessary to preserve the viability of the organ to be transplanted.

**"PROSTHESIS" or "PROSTHETIC APPLIANCE"** means a device used as an artificial substitute to replace a limb or an eye, used to improve, aid or augment the performance of a natural function. In no event will the term "prosthesis" include devices such as eyeglasses, hearing aids, orthopedic shoes, arch supports, orthotic devices, trusses, or examinations for the prescription or fitting thereof.

**"PROTECTED HEALTH INFORMATION (PHI)"** means individually identifiable health information (any health information that can be tied back to an individual). (See Part II, 45 Code of Federal Regulations Part 164.501).

**"PSYCHOLOGIST"** means a person who holds a Ph.D. in clinical psychology, is recognized by the American Board of Examiners in Professional Psychology and who is licensed in and performs such services in accordance with the laws of the state in which such services are provided.

**"QUALIFIED BENEFICIARY"** means a participant who qualifies for continuation of coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985, as then constituted or later amended.

**"QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)"** means a judgment, decree or order (including judicially approved settlement agreements having the effect of an order) which provides for child support with respect to a child of a participant under this Plan or provides health benefit coverage to such a child, and qualifies with the requirements set forth in this Plan. The QMCSO must be a judgment or decree issued by a court of competent jurisdiction or a state agency that administers child support enforcement programs.

**"REGISTERED NURSE"** means a professional nurse who has the right to use the title registered nurse (RN), other than one who ordinarily resides in the patient's home or who is a member of the patient's immediate family.

**"REINSURER"** means the insurance company providing the excess risk insurance maintained by the company.

**"RESIDENTIAL TREATMENT FACILITY"** means a 24-hour inpatient facility established for the purpose of mental health and/or chemical dependency treatment and approved as such by a state department or agency having authority over such programs.

**"ROOM AND BOARD"** means all charges commonly made by a hospital for room and meals and for all general services and activities essential to the care of registered bed patients.

**"SPECIAL CARE UNIT"** means a section, ward, or wing within the hospital which is separated from other hospital facilities and:

- (a) is operated exclusively for the purpose of providing professional care and treatment for critical injuries or illnesses;
- (b) has special supplies and equipment, necessary for such care and treatment, available on a standby basis for immediate use; and
- (c) provides room and board and constant observation and care by a registered nurse (RN) and other specially trained hospital personnel.

**"SPOUSE"** means a person to whom a covered employee is legally married, as determined and defined by the laws of the state of the covered employee's residence.

**"STEPCHILD"** means any natural or adopted child of any employee's current spouse, and any natural or adopted child of a former spouse of the employee if the natural parents of that natural or adopted child are both deceased.

**"SURGICAL PROCEDURE"** means cutting, suturing, treatment of burns, correction of fractures, reduction of dislocations, manipulation of joints under general anesthesia, electro-cauterization, tapping (paracentesis), application of plaster casts, administration of pneumothorax, endoscopy, the injection of sclerosing solutions, and obstetrical procedures.

**"TERMINALLY ILL"** means having a life expectancy of six months or less due to an illness from which the participant is not expected to recover. This is usually a chronic illness or condition for which there is no known cure.

**"TOTAL DISABILITY" and "TOTALLY DISABLED"** mean:

- (a) In the case of the covered employee, due to illness or injury, he or she is wholly and continuously prevented from performing the material duties of his or her regular occupation, including any occupation for which the employee is reasonably qualified by reason of education, training or experience;
- (b) In the case of a covered dependent, due to illness or injury, he or she is wholly and continuously prevented from engaging in substantially all of the material activities of a person of the same gender and age who is in good health.

**"URGENT CARE CLAIM"** means any claim for medical care or treatment with respect to which the application of the time periods for making

non-urgent care determinations could seriously jeopardize the life or health of the participant or the participant's ability to regain maximum function, or, in the opinion of a physician with knowledge of the participant's medical condition, would subject the participant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

**"VISIT"** means each attendance to the covered participant by a physician or medical practitioner (i.e., consultation or treatment).

**"WAITING PERIOD"** means the period that must pass before coverage for an employee or dependent who is otherwise eligible to enroll under the terms of the Plan can become effective.

**"WELL-BABY CARE" or "WELL-CHILD CARE"** means pediatric preventive services appropriate to the age of a child from birth to age two, and to include well-child care to age seven, as defined by current Recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Group plans which provided coverage for pediatric vaccines as of May 1, 1993, may not reduce or eliminate this coverage. Failure to comply will result in an excise tax penalty equal to the penalty for plans that fail to provide COBRA coverage.

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## PLAN INFORMATION

Employer: Black Hills Special Services Cooperative

Plan Sponsor: Black Hills Special Services Cooperative  
2885 Dickson Drive  
P. O. Box 218  
Sturgis, South Dakota 57785-0218

Employer Identification #: 45-0422625

Group Number: 47005

Effective Date: July 1, 1993  
This document includes all amendments through September 1, 2011.

Plan Year: July 1 through June 30

Plan Administrator: Black Hills Educational Benefits Cooperative  
P.O. Box 219  
Sturgis, South Dakota 57785-0218

Address for Legal Services: Black Hills Special Services Cooperative  
2885 Dickson Drive  
P. O. Box 218  
Sturgis, South Dakota 57785-0218

Plan Costs: The Plan Sponsor and the employees pay the costs of this Plan.

Type of Benefits: Medical Benefits

Type of Administration: Contract Administration

Third Party Administrator: First Administrators, Inc.  
P.O. Box 8150  
Rapid City, SD 57709-8150

Authority to Amend Plan: Business Manager

Administration and Plan Administrator Authority: The Plan is administered through the local offices of the Plan Administrator to which the participant is associated. The Plan Administrator has retained the services of an Independent Benefit Services Administrator experienced in claims processing.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Benefit Services Administrator and Plan Administrator.

The Plan Administrator has the full and final authority to decide all questions or controversies of whatever character arising in any manner between any parties or persons in connection with the Plan or the interpretation thereof, including the construction of the language of the Summary Plan Description, and any writing, decision, benefit eligibility and determination, instrument or accounts in connection with same and with the operation of this Plan or otherwise, which shall be binding upon all persons dealing with this Plan or claiming any benefits thereunder, except to the extent that the Plan Administrator may subsequently determine, in their sole discretion, that their original decision was in error or to the extent such decision may be determined to be arbitrary or capricious by a court or arbitrator having jurisdiction over such matters. If your employer is unable to fund this Plan, you may be financially responsible for any incurred and unpaid claims.

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# NOTES