



**Douglas School District No. 51-1
Healthcare Benefit Plan**

January 1, 2010

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January 1, 2010

TO ALL PLAN PARTICIPANTS OF DOUGLAS SCHOOL DISTRICT

This Employee Group Benefit Booklet summarizes the benefits available to a participant in the Healthcare Benefit Plan. You should review it thoroughly so that you are aware of the benefits provided.

This Healthcare Plan requires that you or your family member have all hospitalizations pre-authorized prior to entering the hospital. The Utilization Review provider is listed on the front of your identification card and on page 1 of this booklet. Please see Article III of this booklet for further details regarding your responsibilities under this portion of the Plan.

Your Employer has selected a Preferred Provider Organization Network to lower the cost of your healthcare. Use of the Network will help reduce your out-of-pocket medical expenses. Choosing physicians, clinics and hospitals who are members of a network is strongly encouraged.

First Administrators, Inc. has been retained by your employer to help administer this benefit package. Our main responsibility is the administration of the claims paying process. We make sure that the benefits available to you under this plan are paid promptly and accurately.

You are encouraged to contact our office with any questions regarding your plan benefits or the filing of a claim. Claim forms are available from your employer, or from First Administrators, Inc.

Sincerely,

A handwritten signature in black ink, appearing to read 'Trista Hedderman', with a long horizontal flourish extending to the left.

Trista Hedderman, Business Manager
Douglas School District

A handwritten signature in black ink, appearing to read 'Debbie Miner', written in a cursive style.

Debbie Miner
President and Chief Executive Officer

DOUGLAS SCHOOL DISTRICT #51-1

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This Summary Plan Description follows a number sequence.
It is not necessary that it include all articles or numbers in sequence to be correct.

PLAN SPECIFICATIONS

EMPLOYER	Douglas School District #51-1
PLAN ADMINISTRATOR	Douglas School District #51-1 400 Patriot Drive Box Elder, South Dakota 57719
PLAN	Douglas School District Employee Healthcare Plan
BENEFIT SERVICES ADMINISTRATOR	First Administrators, Inc. 512 Main Street, Suite 200 PO Box 8150 Rapid City, South Dakota 57709-8150 Phone: 1-605-343-2509 -or- 1-800-658-3073
PARTICIPANT	Employees of Douglas School District #51 as defined herein.
EFFECTIVE DATE	July 1, 1984 This document includes all amendments through January 1, 2010.
CONTROL NUMBER	20050
UTILIZATION REVIEW	1-800-782-9955
PREFERRED PROVIDER ORGANIZATION NETWORKS	SelectFirst™ A current listing is available on the Internet at www.firstadministrators.com .
PHARMACY NETWORK	Pharmaceutical Technologies, Inc. (NPS) 1-800-546-5677 A current listing is available on the Internet at www.pti-nps.com .

**DOUGLAS SCHOOL DISTRICT #51-1
SCHEDULE OF BENEFITS**

Administered by First Administrators, Inc.

Group #: 20050

Effective Date: January 1, 2010

This Schedule is a brief summary of benefits under this plan and is for your convenience and is not a complete list.
Please review this entire Summary Plan Description to determine your complete benefits.

All benefits are subject to the following deductibles, coinsurance and maximums unless otherwise stated.				
Note: Claims must be received within 12 months from the day charges are incurred.				
MEDICAL BENEFITS	PATIENT'S LIABILITY		GENERAL PLAN LIMITS	PAGE
Medical Deductible: (per calendar year) - Individual - Two Party - Family	\$750 \$1,250 \$2,250		Common accident applies. The deductible is integrated for both In-Network and Out-of-Network Services.	32
Out-of-Pocket Maximums: (per calendar year) - Individual - Two Party - Family	\$2,250 \$3,750 \$4,500		Includes calendar year deductible. The out-of-pocket maximums are integrated for both In-Network and Out-of-Network Services.	32
MEDICAL BENEFITS	PLAN'S LIABILITY		GENERAL PLAN LIMITS	PAGE
	IN NETWORK	OUT OF NETWORK		
Coinsurance Percentage:	80%	70%		32
NOTE: The In-Network coinsurance percentage will apply to "Emergency Medical Services" if the participant is unable, due to his or her condition, to receive treatment from an In-Network provider.				
MEDICAL PLAN'S MAXIMUM LIABILITY				PAGE
Lifetime Maximum	\$2,000,000 except as limited herein.			32
Utilization Review: The Utilization Review Program includes Pre-admission Certification and Pregnancy Program. Please refer to the Plan Specifications for contact information.				22
Penalty for Non-Compliance: All eligible charges relating to hospital confinement, including hospital or facility, doctor and diagnostic x-ray and lab expenses may be reduced by 20% up to a maximum of \$750 for any single hospitalization if the Participant fails to comply with the requirements of the Utilization Review Program.				25
Self-Audit Billing Credit: 25% of the amount eliminated or reduced for provider billing errors found by participants. Maximum credit of \$1,000 per calendar year.				52
MEDICAL BENEFITS	PLAN'S LIABILITY		GENERAL PLAN LIMITS	PAGE
	IN NETWORK	OUT OF NETWORK		
Allergy Testing and Injections	80%	70%		29
Ambulance	80%	70%	To and/or from hospital if medically necessary.	31
Anesthesia	80%	70%		29
Annual Physical Examination (Limited Wellness Benefit)	50%	50%	Benefit applies to covered employee and/or spouse. Deductible waived, paid at 50% to a reimbursed maximum of \$100 payment per calendar year.	36
Baseline Mammography	80%	70%	Baseline low dose mammography services, including two views of each breast, are limited to one examination each year.	32
Chiropractic Care	80%	70%	Manipulation or adjustment of Spinal Column. Limited to 26 visits per calendar year.	30

MEDICAL SCHEDULE OF BENEFITS (Continued)

Note: Claims must be received within 12 months from the day charges are incurred.				
MEDICAL BENEFITS	PLAN'S LIABILITY		GENERAL PLAN LIMITS	PAGE
	IN NETWORK	OUT OF NETWORK		
Dental Services Covered Under The Medical Plan - Temporomandibular Joint Treatment(TMJ)	80%	70%	Prior approval is required. Intra-oral devices and any other non-surgical method to treat TMJ are limited to a maximum lifetime benefit of \$2,000.	
Durable Medical Equipment	80%	70%	Rental not to exceed the purchase price.	
Emergency Room Services	80%	80%		
Home Health Care	80%	70%		
Hospice Care - Bereavement	80%	70%	For expenses incurred within 3 months of death.	
Maternity Expense - Newborn Hospital Expense	80%	70%	Payable for all female participants. Includes professional services and circumcision when performed prior to discharge.	
Mental Health Services and Alcohol or Drug Dependency - Inpatient - Outpatient	80%	70%	Pre-admission certification is required for inpatient services. Limited to 26 visits per calendar year.	
Mental Health Services - Inpatient	80%	70%	Limited to 30 days per calendar year.	
Alcohol or Drug Dependency - Inpatient	80%	70%	Limited to 30 days during any 6-month period. Lifetime maximum of 90 days per person for alcoholism or drug dependency treatment.	
Note: Two days of partial hospitalization (minimum 6 hours to maximum of 12 hours) will count as one day of confinement.				
Morbid Obesity	80%	70%	Prior approval is required. Lifetime limit of one surgical procedure.	
Organ and Bone Marrow Transplant Benefits - Donor Expenses - Lodging and meals - Transportation, lodging & meals	80%	70%	Prior approval is required. Limited to \$30,000 per transplant. Lodging and meals up to \$150 per day for individual accompanying the covered recipient. Limited to \$3,000 per transplant.	
Outpatient Surgery	80%	70%		
Pre-Surgery Testing	100%	100%	Paid at 100% if done as an outpatient.	
Private Duty Nursing	80%	70%		
Prostate Cancer Screening	80%	70%		
Radiation Therapy and Chemotherapy	80%	70%		
Routine Colorectal Cancer Screening	80%	70%	Non-medically necessary screenings are a covered benefit for all covered members age 50 and older. Limit one colonoscopy every ten years. Lifetime screening maximum: \$5,000. This benefit is not included in the Limited Wellness Benefit.	
Second Surgical Opinion Expense	100%	100%	Limited to maximum allowable fee, if opinion obtained prior to surgery.	
Skilled Nursing Facility	50%	50%	Maximum of 90 days per calendar year.	

PRESCRIPTION DRUG PROGRAM BENEFITS

PRESCRIPTION DRUG BENEFITS	PLAN PAYS	GENERAL PLAN LIMITS	PAGE
Retail: - Generic - Formulary Brand Name - Non-Formulary Brand Name	70% 65% 60%	Subject to the deductible. Limited up to 30-day supply; maintenance prescriptions may be filled up to a 90-day supply.	27
Mail Order: - Generic - Formulary Brand Name - Non-Formulary Brand Name	70% 65% 60%	Subject to deductible. Limited up to a 90-day supply.	

Items Covered:

- A. Drugs or medicines authorized to be distributed by prescription and insulin;
- B. Oral contraceptives;
- C. Prenatal vitamins;
- D. Compounded medication of which at least one ingredient is a prescription legend drug; and
- E. Retin A for non-cosmetic purposes requires prior authorization for covered persons over age 35.

Items NOT Covered:

- A. 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;
- B. Prescription drugs which may be properly received without charge under local, state, or federal governmental programs, including Worker's Compensation or similar laws;
- C. 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;
- D. Drugs labeled: "Caution--limited by federal law to investigational use," or experimental drugs, even though a charge is made;
- E. Charges in connection with rest or custodial care, personal comfort items, health club dues or fees for weight loss clinics;
- F. Impotence drugs unless impotence is the result of a physical illness or injury;
- G. Contraceptive devices including Levonorgestrel (Norplant);
- H. Vitamins, except prenatal vitamins;
- I. Drugs for cosmetic purposes, such as Minoxidil (Rogaine), Eflornithine (Vaniqa), and Tretinoin (Retin A);
- J. Nicorette Chewing Gum, Habitrol, or similar smoking cessation prescriptions;
- K. Diabetic supplies under the prescription drug benefit, see Section 5.03 for coverage under the Medical Benefit;
- L. Immunization agents, biological sera, blood or blood plasma;
- M. Infertility drugs with no other approved indication; and
- N. Drugs for weight loss and appetite suppressants.

GENERAL INFORMATION		PAGE
Medicare Qualifying Participants and Dependents	This Plan is Primary for employees and their dependents. This Plan is a Supplement to Medicare for non-employee participants and their dependents.	63
Effective Date and Waiting Period	First day of employment with proper enrollment, subject to the provisions of Section 1.01.	5
Dependent Unmarried Child Maximum Age	To age 19, 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.	43
Termination of Coverage	End of month after date of termination of employment or loss of eligibility, with an option to purchase continuation of benefits.	6
Leave approved by School Board	Up to time limit approved by Board of Education.	-
Retirement	Eligible retired employees and/or participating dependents may continue coverage to age 65, as outlined in Section 1.10. (In the event Federal law increases the eligibility age for Medicare, this Plan will abide by the Federal law requirements.)	10

LIFE INSURANCE AND ACCIDENTAL DEATH DISMEMBERMENT

All Eligible Employees	Life Insurance and Accidental Death & Dismemberment Insurance. See your separate Group Term Life Certificate of Insurance for details.
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ARTICLE I

Eligibility

S1.01 PARTICIPANT ELIGIBILITY

For permanent employees who work at least 20 hours per week with six months or more of projected employment and who are active participants in the South Dakota Public Retirement System, eligibility for coverage under the Plan begins when you are "actively at work". Coverage begins after satisfaction of the waiting period shown in the Schedule of Benefits, completion of the enrollment application provided by the Plan Administrator, and authorization of payment of your cost of coverage, if any, through payroll deduction.

If the employee is eligible for coverage, but not actively at work on the day his coverage is scheduled to begin because of any reason other than his 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 workday

After completion of the waiting period (see *Article IX* for definition of *Waiting Period*) the employee has 31 days to elect coverage without the necessity of submitting a written request for late enrollment.

On the date an employee becomes covered on this Plan, he shall then be considered a Plan participant. The first day of coverage shall be that individual's "effective date."

Participant coverage is restricted by the limitations set forth in the Plan Pre-Existing Condition Exclusion Period, Section 1.09.

This Plan also covers former employees and eligible dependents who have continued coverage under the Continuation of Benefits sections of this Plan. Covered individuals will be classified by the Plan Administrator in one of the following classifications:

- A. Individual Coverage: is available to all eligible employees, or former employees qualifying under Continuation of Benefits.
- B. Two-Party Coverage: is available to all eligible employees and one eligible dependent or former employees and their eligible dependent qualifying under Continuation of Benefits. The two-party unit has to represent the entire family unit of the employee or former employee unless written proof of coverage in another employer sponsored group plan is provided to the District.
- C. Family Coverage: is available to all eligible employees and their eligible dependents, or former employees and their eligible dependents qualifying under Continuation of Benefits.

Additionally, this Plan covers elected or appointed School Board members. The effective date for School Board members is the first day of the month following the day they take office with proper enrollment.

S1.02 DEPENDENT ELIGIBILITY

For the purpose of this Plan, a participant's dependent is any person meeting the definition of *Dependent* in *Article IX* of this Plan. No person is eligible to be covered twice under this Plan, i.e. no one can be a dependent and a participant, or a dependent of two participants, etc.

A participant can automatically elect dependent coverage on the later of the following:

- A. The date the participant is initially covered by this Plan.
- B. The date the dependent is acquired by the participant.

Coverage for a newborn child or an adopted child of a participant begins at the moment of birth or, in the case of an adopted child, at the beginning of the 6-month adoption period. The child may be born to or adopted by a participant who does not have the required Dependent coverage under this Plan at the time of the child's birth or adoption. If so, coverage for the child must be elected within 31 days from the date of birth or adoption. If the employee applies for dependent coverage prior to the child's birth or adoption, coverage for that child shall begin on the date of that child's birth provided the appropriate employee contribution for coverage has been made.

Dependent coverage is restricted by the limitations set forth in the Plan Pre-existing Condition Exclusion Period, Section 1.09. However, the Pre-existing Condition Exclusion Period of this Plan does not apply to an adopted child, if the child:

- A. is adopted or placed for adoption prior to his/her 18th birthday; and
- B. becomes covered by this Plan within 31 days of such placement.

The provisions of this section apply to both active employees and individuals who have elected to continue coverage as outlined in Section 2.01.

S1.03 LATE ENROLLMENT

If a request for employee or dependent coverage is made later than 31 days after the employee is first eligible for employee or dependent coverage, the person requesting coverage will be considered a late applicant and must submit a written request for late enrollment to the Plan Administrator.

Late enrollment means an enrollment of an individual 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.

Late applicants, individuals not eligible for a special enrollment period, are subject to an 18-month exclusionary period. At the end of the 18-month exclusionary period late applicants are eligible to join the Plan with no Pre-Existing Condition Exclusion Period. A formal application, available from the participant's employer, must be completed to begin the 18-month exclusionary period.

S1.04 TERMINATION OF COVERAGE

Termination of coverage of a participant will occur on the earliest of:

- A. the date this Plan is terminated and there is no successor plan, or
- B. the participant's class is no longer included in the coverage classes, or
- C. the participant ceases to be a member of the coverage classes because he/she becomes a full-time member of the armed forces of any country, or
- D. if the coverage is contributory, any contribution required of the participant for any coverage under the Plan is not made when due, or
- E. termination of employment for any reason, with an option to purchase a continuation of coverage as outlined in Section 2.01, or
- F. the date the participant receives the lifetime maximum benefit, as specified in the Schedule of Benefits.

The dependent's coverage will cease, regardless of continuation of other dependent coverage:

- A. when the individual ceases to be a dependent as defined herein; or
- B. when the participant is no longer covered under this Plan (except when the participant terminates for having received the maximum lifetime benefit); or

- C. if the coverage is contributory, any contribution required for dependent coverage under the Plan is not made when due, or
- D. the date the dependent receives the lifetime maximum benefit, as specified in the Schedule of Benefits, or
- E. when the dependent becomes eligible for participant coverage hereunder.

S1.05 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. If an individual moves from a high deductible plan to a low deductible plan mid-year, there will be no reimbursement if the high deductible has already been met.

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

Individuals Losing Other Coverage

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 current 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.
- D. under the terms of this Plan, the current employee requests enrollment into this Plan not later than 31 days after an event, as described in (C.) above.

Effective date for Special Enrollment: coverage must begin no later than the first day of the first calendar month as long as the written request for enrollment is made within 31 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 Children's Health Insurance Program (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

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(s) may be enrolled at the same time):

- A. if 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. if a person becomes a dependent of the current employee through marriage, birth, or adoption or placement for adoption.

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

Effective date of Enrollment (Birth, Adoption or Placement): coverage must be effective retroactively to the date of birth, adoption or placement for adoption (Provided the written request for enrollment occurs within 31 days of birth, adoption or placement for adoption).

Effective date of Enrollment (Spouse or Dependent acquired through marriage): coverage must be effective no later than the first day of the first month as long as the written request for enrollment is made within 31 days of marriage.

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:

- the current employee or dependent becomes eligible for a new premium assistance subsidy plan under Medicaid or Children's Health Insurance Program (CHIP).

This dependent special enrollment period will be a period of 60 days beginning on the date of eligibility. (Flexible spending plans and high deductible health plans are not eligible for this special enrollment period.)

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 first day of the month after the request for enrollment is received.

Enrollees joining the Plan through a special enrollment period are subject to the Pre-Existing Condition Exclusion Period outlined in Section 1.09, including the right to demonstrate Creditable Coverage.

S1.08 CREDITABLE COVERAGE PROVISION

Qualifying periods of time during which a participant or dependent had "Creditable Coverage" will be applied toward the satisfaction of the participant's or dependent's pre-existing condition exclusion period. Prior carriers or employers will provide certification regarding a participant's or dependent's prior coverage. In addition, the participant or dependent 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 or dependent's coverage ceases. This certification will be used to determine what portion of the participant's or dependent's pre-existing condition exclusion period, if any, must still be satisfied.

Written requests for certificates must include:

- the name of the individual for whom the certificate is requested;
- the last date that the individual was covered under the plan;
- the name of the participant that enrolled the individual in the plan;
- a telephone number to reach the individual for whom the certificate is requested, in the event of any difficulties;
- 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;
- the address to which the certificate should be mailed; and
- 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 definition of "Creditable Coverage" in Article IX of this Plan.

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.

S1.09 PRE-EXISTING CONDITION EXCLUSION PERIOD

This Plan includes an exclusion period for new participants or dependents 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 or dependent'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 or dependent'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 provision will also be in effect if there is a change in the participant's or dependent's coverage which the participant or dependent elected to make and which increased this Plan's liability.

The pre-existing condition exclusion period works as follows:

If a participant or dependent has a pre-existing, allowable medical condition (physical or mental) within 90 days prior to his/her date of enrollment for medical coverage (this 90-day period is called the look-back period), that allowable condition will not be covered by this Plan until 12 months following the participant's or dependent's date of enrollment.

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.

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.

The pre-existing condition exclusion period never applies to pregnancy, regardless of whether the woman had previous coverage. In addition, a pre-existing condition exclusion period will not be applied to a newborn, an adopted child who is under age 18 at the time of the adoption, or a child placed for adoption who is under age 18 at the time of placement for adoption, if the child becomes covered under a group health plan or other creditable coverage within 30 days of the birth, adoption, or placement for adoption. This exception does not apply, however, after the child has a break in coverage of 63 or more consecutive days.

All pre-existing condition exclusion periods (and accompanying 90-day look-back periods) for *special enrollees* begin on the participant or dependent's effective date.

Pre-existing condition exclusion periods (and accompanying 90-day look-back periods) for *new hires* will begin on the date the participant enters a class eligible for coverage.

S1.10 RETIREE COVERAGE

A continuation of benefits may be purchased upon retirement by Plan participants who have worked for the District at least 10 years and have been participants in the District's Plan for the last five years when they retire at age 50 or older; such continuation must terminate at age 65. Dependents may continue with the retiree if the dependent has been a participant in the District's Plan for the last five years; such continuation may be purchased after retiree's coverage terminates, up to 18 months, or until the dependent reaches age 65, whichever is shorter. The cost of coverage under this provision shall be 115% of the then current District rate for similar coverage. (In the event Federal law increases the eligibility age for Medicare, this Plan will abide by the Federal law requirements.)

ARTICLE II

Continuation of Benefits

S2.01 CONTINUATION OF COVERAGE UNDER FEDERAL LAW - COBRA

The following information about your right to continue your 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 you when you would otherwise lose your group health coverage under the Plan. It can also become available to your 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 you and your family, and what you need 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. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand your rights beyond COBRA's requirements.

For additional information about your rights and obligations under the Plan and under federal law, you should contact Douglas School District No. 51-1, which is the Plan 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." You, your spouse, and your 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 of the Plan is available in other portions of this Plan.

Who is Entitled to Elect COBRA?

If you are an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because your hours of employment are reduced; or your employment ends for any reason other than your 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:

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

If you are the dependent child of an employee, you will be entitled to elect COBRA if you lose your group health coverage under the Plan because any of the following qualifying events happens:

- your parent-employee dies;
- your parent-employee's hours of employment are reduced;
- your parent-employee's employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits;
- the parents become divorced or legally separated; or
- you stop 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. You 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 to you only if you notify the Plan 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, **YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

Electing COBRA Coverage

To elect COBRA, you must complete the Election Form that is part of the Plan's COBRA election notice and submit it to the Plan Administrator. An election notice will be provided to qualified beneficiaries at the time of a qualifying event. You may also obtain a copy of the Election Form from the Plan Administrator. Under federal law, you 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 you at the time of your qualifying event to decide whether you want to elect COBRA under the Plan.

Mail the completed Election Form to:

Douglas School District No. 51-1
Business Office
400 Patriot Drive
Box Elder, SD 57719

The Election Form must be completed in writing and mailed to the 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.

Your election must be postmarked no later than 60 days after the date of the COBRA election notice provided to you at the time of your qualifying event. **IF YOU DO NOT SUBMIT A COMPLETED ELECTION FORM BY THIS DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

If you reject COBRA before the due date, you may change your mind as long as you furnish 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.

You do not have to send any payment with your Election Form when you 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 you complete the Election Form, you must notify the Plan Administrator if any qualified beneficiary has become entitled to Medicare and, if so, the date of Medicare entitlement. If you become entitled to Medicare (or first learn that you are entitled to Medicare) after submitting the Election Form, immediately notify the Plan Administrator of the date of your 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, you should take into account that a failure to elect COBRA will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of COBRA may help you avoid such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you elect COBRA coverage and do not exhaust COBRA coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage under the Plan ends because of one of the qualifying events listed above. You will also have the same special enrollment right at the end of COBRA coverage if you get COBRA coverage for the maximum time available to you.

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 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 loss of 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 8 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 your 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. You must notify the Plan 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 you notify the Plan Administrator in a timely fashion, all of the qualified beneficiaries in your 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 you notify the Plan Administrator in writing of the Social Security Administration's determination of disability within 60 days after the latest of:

- the date of the Social Security Administration's disability determination;
- the date of the covered employee's termination of employment or reduction of hours; or
- 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.

You 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 Plan 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, 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.)

The extension due to a second qualifying event is available only if you notify the Plan 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 Plan 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:

- any required premium is not paid in full and on time;
- 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);
- a qualified beneficiary becomes entitled to Medicare benefits after electing COBRA;
- the employer ceases to provide any group health plan for its employees; or

- 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).

You must notify the Plan 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 you provide notice to the Plan 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, you must notify the Plan 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. Douglas School District No. 51-1 will require repayment to the Plan of all benefits paid after the termination date, regardless of whether or when you provide notice to the Plan 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 your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

Temporary Premium Reduction

The federal stimulus package, which was enacted as the American Recovery and Reinvestment Act of 2009 (ARRA) temporarily reduces the premium for COBRA coverage for eligible individuals. COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1985) allows certain people to extend employer-provided group health coverage, if they would otherwise lose the coverage due to certain events such as divorce or loss of a job.

Individuals who are eligible for COBRA coverage because of their own or a family member's involuntary termination from employment that occurred from September 1, 2008 through December 31, 2009 and who elect COBRA, may be eligible to pay a reduced premium. Eligible individuals pay only 35% of the full COBRA premiums under their plans for up to nine months. This premium reduction is generally available for continuation coverage under the Federal COBRA provisions, as well as for group health insurance coverage under state continuation coverage laws.

Special rules apply for HIPAA's pre-existing condition rules during this extended election period. The period beginning on the date of the qualifying event and ending on the beginning of the period of coverage is disregarded for purposes of the 63-day break in creditable coverage rules of HIPAA.

If an individual was offered Federal COBRA continuation coverage as a result of an involuntary termination of employment that occurred at any time from September 1, 2008 through February 16, 2009, and he or she declined COBRA coverage at that time or elected COBRA and later discontinued it, he or she may have another opportunity to elect COBRA coverage and pay a reduced premium.

If the participant has any questions about his or her rights and obligations under this Plan, the participant should contact the Plan Administrator.

Payment for COBRA Coverage

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

Your first payment and all monthly payments for COBRA coverage must be made payable to Douglas School District No. 51-1 and mailed to:

Douglas School District No. 51-1
Business Office
400 Patriot Drive
Box Elder, SD 57719

Your payment is considered to have been made on the date that it is postmarked. You will not be considered to have made any payment by mailing a check if your check is returned due to insufficient funds or otherwise.

If you elect COBRA, you do not have to send any payment with the Election Form. However, you must make your first payment for COBRA coverage not later than 45 days after the date of your election. (This is the date your Election Form is postmarked, if mailed, or the date your 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."

Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your 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 45th day after the date of her COBRA election). You are responsible for making sure that the amount of your first payment is correct. You may contact the Plan Administrator to confirm the correct amount of your first payment.

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

If you do not make your first payment for COBRA coverage in full within 45 days after the date of your election, you will lose all COBRA rights under the plan.

After you make your first payment for COBRA coverage, you 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 to you at the time of your 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 you make a monthly payment on or before the first day of the month to which it applies, your COBRA coverage under the Plan will continue for that month without any break. The Plan Administrator will not send periodic notices of payments due for these coverage periods (that is, we will not send a bill to you for your COBRA coverage - it is your responsibility to pay your COBRA premiums on time).

Although monthly payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your COBRA coverage will be provided for each month as long as payment for that month is made before the end of that month's grace period. However, if you pay 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, your 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(s) you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a monthly payment before the end of the grace period for that month, **YOU 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 Douglas School District No. 51-1 during the covered employee's period of employment with Douglas School District No. 51-1 is entitled to the same rights to elect COBRA as an eligible dependent child of the covered employee.

If You Have Questions

Questions concerning your Plan or your COBRA rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information

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

Douglas School District No. 51-1
Business Office
400 Patriot Drive
Box Elder, SD 57719

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 SPD (if the participant is not sure whether this is the Plan's most recent SPD, he/she may request the most recent one from the Benefit Services Administrator or the Plan Administrator).

S2.02 FAMILY AND MEDICAL LEAVE ACT OF 1993

This 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 at least 12 months by the employer and a minimum of 1,250 hours of service with such employer during the previous 12-month period, 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 had the employee 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. Participants please see the employer for more information.

S2.05 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

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.

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:

- the name and last known mailing address of the participant and the name and address of each child to be covered by this Plan;
- 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; and
- 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 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.

S2.07 UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT

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 the person may elect to continue 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 person'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 8-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 Military Health System, 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 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 you are a covered employee called to a period of active service in the Uniformed Service, you should check with the Plan Administrator for a more complete explanation of your rights and obligations under USERRA. In the event of a conflict between this provision and USERRA, the provisions of USERRA, as interpreted by us or your former employer, will apply.

ARTICLE III

Mandatory Cost Containment Program

S3.00 BENEFIT MANAGEMENT PROVISIONS

To ensure that cost-effective services are provided, SelectFirstTM 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.

S3.01 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.

The Benefit Services Administrator can be reached at the telephone number listed on the Plan Specifications page, Page 1, of this Summary Plan Description.

S3.02 UTILIZATION REVIEW

Planned inpatient stays must be pre-certified to the Utilization Review Unit prior to the actual admission. Unplanned admissions must be pre-certified 48 hours or on the first business day following weekend or holiday admissions. 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.

The Utilization Review Company can be reached at the telephone number listed on the Plan Specifications page, Page 1, of this Summary Plan Description, and on the participant's identification card. The phone lines are available 24 hours per day, every day of the year.

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.

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

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 seventy-two 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

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

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

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.

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

S3.03 PHYSICIAN REVIEW

Our 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.

S3.04 CONTINUED STAY REVIEW

The Utilization Review staff does not assign lengths of stay when an inpatient stay is certified. Each admission is closely monitored to verify that services being provided remain medically necessary. This review begins on the second day of a hospital stay. Physician reviewers are consulted whenever services being provided or requested do not meet medical necessity standards.

This Healthcare Benefit Plan requires hospitalizations be reviewed prior to admission to any hospital (Emergency Admissions please see Urgent Care Review in Section 3.01). **The Utilization Review Company's name and telephone number are listed on Page 1, Plan Specifications, of this booklet and on the front of your identification card.**

Utilization Review is not required (but is recommended) 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. (See Section 5.16 for details.)

Utilization Review does not guarantee benefits under this Plan. Utilization Review merely means the length of stay requested is consistent with the diagnosis. Actual benefits provided under this Plan are determined based on the provisions of the Plan, including the patient's eligibility to receive benefits. Please call First Administrators, Inc. the Benefit Services Administrator, at 1-605-343-2509 to determine benefits under this Plan.

S3.05 PREGNANCY PROGRAM

The Pregnancy Program is designed to provide confidential educational services and risk assessment during pregnancy. As soon as the covered employee or female dependent spouse is expecting, within the first trimester or soon thereafter, the participant or dependent should call the Utilization Review Company. If complications arise during the pregnancy, the participant will be assisted in receiving the most cost-effective, quality care necessary.

The Utilization Review Company can be reached at the telephone number listed on the Plan Specifications page, Page 1, of this Summary Plan Description, and on the participant's identification card.

S3.06 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.

S3.07 PENALTY FOR NON-COMPLIANCE

All eligible charges relating to hospital confinement, including hospital or facility, doctor and diagnostic x-ray and lab expenses may be reduced by 20% up to a maximum of \$750 for any single hospitalization if the Participant or Dependent fails to comply with the requirements of this Utilization Review program.

Any amount not payable as a result of this 20% reduction shall not be covered under any other benefit provision of this Plan.

S3.08 CONCURRENT CARE

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. See Section 10.03 of this Plan for an explanation of the appeals procedure.

S3.09 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.

S3.10 RIGHT OF APPEAL

The participant has the right to a full and fair review in case of an adverse benefit determination in response to a pre-admission Utilization Review request or to a request for continued stay in a facility. An adverse benefit determination is one that denies or reduces benefits.

The participant must appeal an adverse benefit determination within 180 days from the notice of the Utilization Review Company's decision. To appeal an adverse benefit determination, call the Utilization Review Company that provided the decision at the telephone number listed on the front of the participant's identification card. For appeals involving medical urgency, the participant may request an expedited appeal. In an expedited appeal, information, including the decision, will be communicated by telephone, facsimile, or other similarly prompt method.

In a medically urgent situation, notification of the decision on the appeal will be provided within 72 hours of receipt of the appeal. For non-urgent situations, response to the appeal will be provided within 30 days of the request.

S3.11 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

ARTICLE IV

Prescription Drug Benefits

S4.02 PRESCRIPTION DRUGS

Retail prescription drugs: The deductible provisions stated in the Schedule of Benefits apply to the prescription drug benefit. After the deductible is met, prescription drugs are subject to the following coinsurance provisions:

1. 70% coinsurance per Generic Equivalent prescription;
2. 65% coinsurance per Preferred (Formulary) Brand Name prescription; and
3. 60% coinsurance per Non-Preferred (Non-Formulary) Brand Name prescription.

The retail prescription drug benefit is limited to a 30-day supply. However, maintenance medication prescriptions may be filled up to a 90-day supply when prescribed by a physician. Participants must present the proper identification and pay the total charge to the pharmacy at the time the prescription is received. When a pharmacy participating in the network is used, the patient need not file their claim, the pharmacy will electronically file the claim to First Administrators, Inc.

Mail Order prescription drugs: A mail order option is available for maintenance medication prescriptions. Maintenance medication prescriptions may be filled up to a 90- day supply when prescribed by a physician. Maintenance prescriptions filled by mail may be filled up to a 90- day supply when prescribed by a physician and are subject to the deductible provisions stated in the Schedule of Benefits. After the deductible is met, prescription drugs are subject to the following coinsurance provisions:

1. 70% coinsurance per Generic Equivalent prescription;
2. 65% coinsurance per Preferred (Formulary) Brand Name prescription; and
3. 60% coinsurance per Non-Preferred (Non-Formulary) Brand Name prescription.

A credit card is needed to order mail order prescription drugs. Details are available from the Employer.

Maintenance prescriptions refer to a drug treatment appropriate to control a specific ongoing condition. The drug may be required for a long time, even a lifetime. When practitioners write prescriptions, they indicate whether refills are allowed and, if so, how many. You may not receive benefits for a refill if:

1. sufficient time has not elapsed since the last prescription was filled. Sufficient time means that at least 75% of the medication has been taken according to the instructions given by the practitioner;
2. the refill is to replace medications that have been lost, stolen, or used inappropriately;
3. the refill is in excess of the number authorized by the practitioner; or
4. the refill is limited by state law.

Generic drugs should be used whenever there is a generic equivalent for the drug you are taking. A generic equivalent means a prescription drug available from more than one drug manufacturer which has the same active therapeutic ingredient as a brand or trade name prescription drug.

When a retail pharmacy that is not participating in the network is used, the participant must file the claim directly with First Administrators, Inc. You may not be reimbursed for the full amount you pay for a prescription drug from a non-participating pharmacy. You are responsible for any difference between the billed charge and the maximum allowable fee.

Formulary Brand/Preferred Brand Drugs - Preferred Brand Drugs are safe and cost-effective medications. The list of Preferred Brand Drugs (provided with your pharmacy identification card) serves as a guide to physicians when deciding which medications to prescribe for their patients. Based upon the clinical judgment of physicians, pharmacists, and other experts, the list suggests medications the physician might prescribe when there is a choice of medications that produce the same result. The list represents the current standards of care regarding appropriate medication options. If your physician prescribes a drug from the Preferred Brand Drugs list, your out-of-pocket costs will be reduced.

Prior authorization may be required for some drugs. Prior authorization allows a drug that is not normally covered by the Plan to be allowed when used to treat a covered medical condition. Certain excluded drugs may have a dual purpose or multiple indications and prior authorization will be required for these drugs.

To obtain prior authorization, you or your health care provider must request the prior authorization by calling or writing to the Benefit Services Administrator with the following information:

- name and age of patient;
- participant's name, group number, and identification number;
- name of drug and dosage;
- the reason the drug should be covered; and
- the length of time the drug should be covered.

The Benefit Services Administrator will respond to a request for prior authorization within 72 hours for medically urgent situations and 15 days for non-medically urgent situations.

If your request for prior authorization is denied in whole or in part, you have the right to a full and fair review of the adverse determination.

You must appeal an adverse determination within 180 days of the Benefit Services Administrator's decision. To appeal an adverse determination, call the Benefit Services Administrator at the telephone number listed on your identification card. For appeals involving medical urgency, you may request an expedited appeal. In an expedited appeal, information, including the decision, will be communicated by telephone, or if you request, in writing.

In a medically urgent situation, notification of the decision on the appeal will be provided within 72 hours of receipt of the appeal. For non-urgent situations, response to the appeal will be provided within 30 days of the request.

ARTICLE V

Medical Benefits

S5.01 ELIGIBLE EXPENSES

The following services are eligible expenses for participants and dependents covered under this Plan. Eligible expenses are subject to the deductible and coinsurance percentage as shown in the Schedule of Benefits and are limited by certain provisions listed in the General Exclusions section of this Plan.

S5.02 HOSPITAL INPATIENT EXPENSES

Hospital Room and Board - an amount per day up to the semi-private room rate for charges incurred for use of the Intensive Care Unit (ICU) when ordered by the patient's primary physician. Observation exceeding 23 hours will be considered an inpatient admission. See Article III of this Plan for proper direction in obtaining a Utilization Review.

Hospital Miscellaneous - all other charges made by a hospital during an inpatient confinement exclusive of personal items or services not necessary to the treatment of illness or injury. Outpatient means there is no room and board charge and the total observation time at the facility does not exceed 23 hours.

S5.03 COVERED EXPENSES

The following medically necessary services are covered expenses in or out of the hospital:

1. **Allergy** tests and allergy injections.
2. **Anesthesia** charges.
3. **Assistant surgeon** charges (if one is required due to the technical aspects of the surgery involved).
4. **Blood** and blood related products (see *Article VIII* for exception).
5. **Cardiac rehabilitation**
 - services rendered under supervision of a Physician and in a medical care facility as defined by this Plan;
 - in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
 - initiated within 12 weeks after other treatment for the medical condition ends and limited to Medicare guidelines for number of visits; and
 - Phase 3 portion is **not** covered.
6. **Cervical collar**, colostomy bag, ileostomy supplies, catheters, and syringes.
7. **Chelation Therapy** only to treat heavy metal poisoning.
8. **Chemotherapy** for treatment of a malignancy.
9. **Cosmetic services.** Cosmetic surgery, treatment, or related hospital admissions, made necessary:
 - by an accidental injury;
 - for correction of congenital deformity when necessary to perform a normal body function; and
 - for reconstructive surgery as necessary for the prompt treatment of a diseased condition.

10. **Dietary services** - but only as an inpatient or when prescribed by a physician for treatment of Phenylketonuria (PKU).
11. **Durable medical equipment**, purchase or rental up to the purchase price (equipment that is not available for purchase will require continuous rental).
12. **Elective Sterilization** - The Plan pays for certain Elective Sterilization procedures such as tubal ligation and vasectomies. These procedures shall be considered the same as any other illness only for:
 - covered participants; and/or
 - covered dependents.

Eligible expenses under this Plan shall not include reversals, or attempted reversal of these procedures.

13. **Equipment, supplies**, and self-management training and education, including medical nutrition therapy, for treatment of persons diagnosed with diabetes as required by South Dakota state law and limited to no more than two comprehensive education programs per lifetime and up to eight follow-up visits per year (diabetic supplies are subject to deductible, then paid at 70% coinsurance).
14. **Eyelid or Eyebrow surgery**. If preoperative formal visual tests indicate correctable impairment of central visual acuity or peripheral vision and a preoperative photograph demonstrate the impingement of the lid margin on the pupil.
15. **Foot Care** if the charges are for the partial or complete removal of nail roots or are necessary in the treatment of a metabolic or peripheral-vascular disease.
16. **Growth hormones**. - but only if all of the following are true:
 - Diagnostic evaluation establishes that "growth hormone deficiency" is the cause of short stature. (Provocative testing demonstrates hormone secretion levels below 10 mg/ml.);
 - Stature (height) is less than the third percentile;
 - Growth velocity is less than 4 to 5 centimeters (1.5 to 2 inches) per year; and
 - Bone age is two years or more behind chronological age.
17. **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. **Hospital** outpatient services.
19. **Hydrotherapy**
 - to restore bodily function from an illness or injury;
 - must produce significant improvement in the patient's condition within a reasonable period of time; and
 - must be performed by a Physician as defined in Article IX.
20. **Laboratory** services.
21. **Manipulation** or adjustment of the spinal column.
22. **Massage therapy** by a Physician, as defined in Article IX, is required to have direct (one on one) patient contact.

23. **Mastectomy** due to diagnosed breast cancer and the following coverage:
 - reconstruction of the breast on which the mastectomy has been performed;
 - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - prosthesis and physical complications of all stage of mastectomy, including lymphedema.

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, in a manner determined in consultation with the attending physician and the patient.
24. **Morbid Obesity** - Surgical treatment of morbid obesity is limited to one surgical procedure per lifetime. See Article IX for definition of Morbid Obesity. Non-surgical treatment of morbid obesity is not covered by this Plan. Prior Approval is required.
25. **Nursing services** (except those of a relative) performed by a Registered Nurse (R.N.), or a Licensed Practical Nurse (L.P.N.).
26. **Occupational therapy** - but not occupational therapy supplies.
27. **Orthopedic braces**, crutches, casts, and prosthetic devices.
28. **Oxygen** and the equipment for its administration.
29. **Pathological** services.
30. **Physical therapy**
 - by a licensed physical therapist;
 - must be in accord with a Physician's exact orders as to type, frequency, and duration; and
 - to improve a body function.
31. **Prescription drugs** requiring a prescription under federal law.
32. **Professional ambulance service** to and/or from the hospital if medically necessary.
33. **Radiation therapy**.
34. **Respiratory/inhalation therapy**.
35. **Services of physicians**
 - hospital visits
 - doctor's office calls
 - doctor's office surgery.
36. **Speech therapy** - but only to restore speech abilities lost due to illness or injury.
37. **Surgery** charges.
38. **Wig** for hair loss due to administration of cytotoxic agents, maximum charge of \$300 and limited to one per lifetime.
39. **X-Ray** services.

S5.05 DEDUCTIBLE

The Deductible is the amount of eligible expenses that Participants and Dependents covered under this Plan must meet each calendar year before Medical benefits can be paid. The deductible amount is shown in the Schedule of Benefits.

S5.06 FAMILY DEDUCTIBLE

When covered family members have met an amount of eligible expenses equal to the Family Deductible amount shown in the Schedule of Benefits, the individual deductible for all other covered members in that family will be considered satisfied for the remainder of the calendar year.

S5.08 COMMON ACCIDENT

When two or more covered family members are injured in the same accident, only one deductible amount applies to all eligible expenses for treatment resulting from that accident.

S5.09 COINSURANCE PERCENTAGE

After eligible expenses incurred in a calendar year equal the deductible amount, eligible expenses incurred in that calendar year shall be paid at the Coinsurance Percentage as specified in the Schedule of Benefits.

S5.10 COINSURANCE LIMIT

When eligible expense incurred in a calendar year and paid under this Plan reach the Coinsurance Limit as shown in the Schedule of Benefits, then eligible expenses shall be paid at 100% for the rest of that calendar year.

S5.14 MAXIMUM BENEFIT

The maximum lifetime benefit per covered person which applies across all plans or options sponsored by the employer for all eligible expenses under this plan is as shown in the Schedule of Benefits.

S5.16 PREGNANCY

Benefits are payable for:

- A. participants; and/or
- B. dependents of participants.

This Plan is in compliance with The Newborns' and Mothers' Health Protection Act of 1996. This Plan will not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a health care provider obtain authorization for prescribing a length of stay not in excess of the above periods.

However, this Plan generally does not prohibit the mother's or newborn's attending health care provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

S5.17 BASELINE MAMMOGRAPHY BENEFIT

Baseline low dose mammography services, including two views of each breast, are limited to one examination each year.

Charges for a mammography examination are eligible under the Annual Physical Examination Benefit, excess charges are eligible as any other Medical benefit.

S5.19 NURSING FACILITY BENEFIT

Eligible expenses incurred during a covered nursing facility confinement are a covered expense if the confinement follows a hospital stay covered under this Plan. The confinement must start within 14 days of release from the hospital and be ordered by the attending physician for the condition necessitating the hospitalization.

The eligible expenses are the inpatient charges - up to the limits shown in the Schedule of Benefits - for the following services and supplies furnished while the patient is under continuous care of the attending physician and requires 24-hour care:

- room, board and other services and supplies furnished by the home for necessary care (other than personal items and professional services),
- use of special treatment rooms,
- x-ray and laboratory examinations,
- physical and speech therapy,
- oxygen, respiratory, and other gas therapy.

S5.21 HOME HEALTH CARE BENEFIT

Charges made by a home health care agency for the following services and supplies furnished to a covered individual in his home for care in accordance with a home health care plan are included as covered medical expenses. This care must be ordered by a physician.

- A. Part-time or intermittent nursing care by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) if the services of a registered graduate nurse are not available.
- B. Part-time or intermittent home health aide services which consist primarily of caring for the individual.
- C. Physical and speech therapy.
- D. Medical supplies, drugs and medicines prescribed by a physician, and laboratory or dietary services provided by or on behalf of a hospital, but only to the extent that they would have been covered under this Plan if the individual had been hospitalized.

Each visit by a representative of a home health care agency, up to four hours, shall be considered as one home health care visit. If the visit exceeds four hours, each period of four hours of home health care service by a representative shall be considered as one home health care visit.

S5.23 HOSPICE CARE BENEFIT

Eligible expenses for an INPATIENT or OUTPATIENT program of hospice care for a terminally ill participant or dependent are covered under this Plan provided that:

- A. the program meets the standards set by the National Hospice Organization, is approved by the Plan Administrator and is licensed, certified or registered if required to do so by the state in which the program operates;
- B. the primary attending physician must provide certification to the Benefit Services Administrator that the life expectancy of the terminally ill person is six months or less;
- C. services must be ordered in writing by the supervising doctor who is directing the hospice care program;
- D. services provided are only those which the person would be legally required to pay for, regardless of insurance coverage; and
- E. services must be provided within the six months of the person's original entry into the program or of the person's re-entry into the program if after a period of remission.

Eligible expenses for INPATIENT hospice care will mean confinement in a free-standing, hospital-affiliated hospice facility.

Eligible expenses for OUTPATIENT hospice care will mean a centrally administered, medically directed and nurse-coordinated program which: is available 24 hours a day, seven days a week; uses a hospice team; and provides a regular program primarily of home care.

A hospice team will mean professional and volunteer workers who provide care to: reduce or abate pain or other symptoms of mental or physical distress; and meet special needs arising out of the stresses of the terminal illness, dying and bereavement. The team must consist of at least a doctor and registered nurse. It could also include social workers, clergymen, counselors, volunteers, clinical psychologists, physiotherapists, and occupational therapists.

Exclusions listed in this Plan apply to this benefit.

S5.24 BEREAVEMENT BENEFIT in connection with hospice care

Eligible bereavement service expenses incurred within three months of the death of a participant or covered dependent by a family unit for bereavement will be covered, provided that on the day immediately prior to death, the terminally ill person was a participant or covered dependent and in a hospice care program covered by this Plan.

Bereavement services means supportive services provided after the death of the terminally ill person, by the members of the hospice team, in counseling sessions with the family unit.

Exclusions listed in this Plan apply to this benefit.

S5.26 ORGAN AND BONE MARROW TRANSPLANTS

The Plan provides benefits for human-to-human organ and bone marrow transplants for participants and their dependents. ***The potential transplant recipient must have been formally evaluated by a transplant facility or team and such evaluation should be submitted in writing to the Plan Administrator for review and approval prior to the transplant procedure.*** The evaluation facility or team must be qualified to render such service or opinion either through experience, special training, education, or similar criteria.

The following expenses are eligible:

I. Donor Expenses

- A. Benefits include surgical, storage, and transportation costs incurred and directly related to the donation of an organ used in a covered transplant. Organ donor expenses are limited as shown in the Schedule of Benefits.

II. Participant or Dependent Recipient Expenses

- A. Reasonable transportation costs to and from the site of the covered organ transplant for the covered person. If the covered dependent is a minor, reasonable transportation costs for one close relative accompanying the dependent is an eligible expense.
- B. Reasonable necessary lodging and meal expenses incurred at the site of the covered organ transplant, up to a daily maximum shown in the Schedule of Benefits, by the individuals accompanying the covered recipient.
- C. Items A and B are limited as shown in the Schedule of Benefits.

No payment is available for any:

- treatments, services or supplies that are educational or provided primarily for research; or
- transplants of artificial (mechanical) or non-human organs.

See Article VIII for additional exclusions.

S5.27 NEWBORN HOSPITAL EXPENSE

Hospital charges incurred by a healthy newborn during the initial period of hospital confinement, will be covered as charges of the mother, provided the newborn is discharged prior to or on the same day as the mother and the mother was covered for the pregnancy. Baby's **routine** delivery charges will be covered as charges of the mother only if the newborn is a **well** baby. If the newborn is ill, suffers an injury, or requires care other than routine care, the baby's charges will not be covered as charges of the mother.

In addition, the following services will be covered during the same time period:

- A. professional services;
- B. circumcision (not covered after newborn is discharged from hospital).

Charges for routine immunizations will not be considered eligible expenses.

Note: When the newborn has other coverage the proper coordination of benefits payment rule will determine the primary payer.

S5.28 MENTAL HEALTH SERVICES, DRUG DEPENDENCY OR ALCOHOLISM BENEFIT

Eligible expense for INPATIENT treatment of these conditions shall be paid as stated in the Schedule of Benefits provided that:

- A. treatment occurs on an inpatient stay not to exceed limits as stated in the Schedule of Benefits; and
- B. treatment occurs in an institution licensed by the appropriate state regulatory agency granting authority to provide mental health, drug dependency or alcoholism care.

Eligible expenses for OUTPATIENT treatment shall be covered and limited to the same extent and as an expense of the Mental Health Services outpatient benefit, as limited in the Schedule of Benefits.

This benefit does not apply to biologically-based mental illness. Biologically-based mental illnesses are covered the same as any other medical illness. See Article IX for definition of Biologically-Based Mental Illness.

S5.29 SECOND SURGICAL OPINION BENEFIT

The Plan will pay the Maximum Allowable Fee for a second surgical opinion, and for a third and final opinion in case of conflict between the first two opinions.

Second or Third Opinion: Must be an opinion of a second or third surgeon acting on a consulting basis only and one who agrees not to perform surgery if deemed necessary, nor to otherwise treat the patient. The opinion of a surgeon who is in association or practice with a prior surgical consultant will not be accepted.

If two of the three surgical opinions agree surgery is unnecessary and the patient proceeds with the surgical operation, the surgeon's fee, as well as hospital charges, will be covered at 50% of the scheduled allowance.

If a second confirming opinion is obtained prior to surgery, then 100% of the Maximum Allowable fee for the second opinion will be paid.

S5.30 DENTAL SERVICES COVERED UNDER MEDICAL BENEFITS

The following services, including those services billed by a dentist or oral surgeon, are covered under the medical portion of this Plan:

- treatment for accidental injuries to natural teeth or facial bones within 90 days of the injury (excludes treatment for injuries associated with the act of mastication);
- for dental work requiring hospitalization, only the Hospital and anesthesia charges are eligible expenses;
- excision of lesions;
- incision of accessory sinus, mouth, salivary glands, or ducts;
- surgical extraction of impacted wisdom teeth;
- anesthesia and hospital charges for dental care provided to a covered person who is a child under age five or severely disabled or has a developmental disability as determined by a licensed physician which places such person at serious risk. Such coverage applies regardless of whether the services are provided in a hospital or a dental office;
- surgical treatment of Temporomandibular Joint (TMJ) dysfunction. Prior to treatment, the claimant will provide proof of medical necessity to the Benefit Services Administrator by A) a dentist's evaluation of the problem to include diagnosis, plan of treatment and cost, and B) a medical doctor's evaluation of the problem to include diagnosis, present or planned treatment, and prognosis. Intra-oral devices and any other non-surgical method to treat TMJ are limited to a maximum lifetime benefit of \$2,000; and
- orthognathic surgery if determined to be medically necessary. Treatment must be for a functional problem not a cosmetic problem. To receive maximum benefits, approval must be obtained prior to surgical treatment commencing. If treatment is provided prior to approval, the charges will be denied.

S5.31 ANNUAL PHYSICAL EXAMINATION

An annual physician examination is a covered expense for participants and covered spouses, as limited in the Schedule of Benefits. Benefits include physician charges, x-ray and laboratory fees and related expenses for a routine examination, including pap smear, urinalysis, prostate examination and mammography examination. Submitted claims should indicate routine well-care examination. Charges for immunizations will not be considered eligible expenses.

Charges that **exceed** the maximum allowable amount, as stated in the Schedule of Benefits, for an annual physical examination will **not** be paid by the Plan.

S5.33 PROSTATE CANCER SCREENING

An annual medically recognized diagnostic examination, including a digital rectal examination and a prostate-specific antigen test is an eligible expense for asymptomatic men aged 50 and over and for men aged 45 and over at high risk for prostate cancer.

For males of any age who have a prior history of prostate cancer, medically indicated diagnostic testing at intervals recommended by a physician, including the digital rectal examination, prostate-specific antigen test, and bone scan are eligible expenses.

Charges for a prostate examination are eligible under the Annual Physical Examination benefit, excess charges are eligible as any other Medical benefit.

S5.35 PRIVATE DUTY NURSING CARE BENEFIT

This Healthcare Plan requires all Private Duty Nursing Care services be pre-approved. It is your responsibility to call the Benefit Services Administrator for approval prior to receiving Private Duty Nursing Care services.

Charges for private duty nursing services are covered medical expenses when ordered by a physician for treatment of illness or injury. Services must be provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) in your home. The private nurse cannot reside in the same household as the covered person nor be related to the covered person.

Each visit by a private duty nurse, up to eight hours, shall be considered as one private duty nursing visit. If the visit exceeds eight hours, each period of eight hours of private duty nursing care shall be considered as one private duty nursing visit.

ARTICLE VIII

General Exclusions

1. **Abortion.** Charges for elective abortion unless the life of the mother is endangered by the continued Pregnancy. However, if complications arise after performance of an abortion, any eligible expenses incurred to treat those complications will be covered under this Plan.
2. **Acupuncture.** Charges for acupuncture or acupressure therapy.
3. **Adoption or surrogate expenses.**
4. **Biofeedback therapy.** Charges for biofeedback.
5. **Blood.** Charges for autologous blood handling and storage (inventorying personal blood) and charges for harvesting, freezing, and storing blood derived peripheral stem cells when cancer is in remission.
6. **Breast surgery.** Charges for mastopexy (breast uplift); augmentation mammoplasty (to enlarge breast), except as provided in Section 5.03; or reduction mammoplasty (breast reduction). However, breast reduction surgery is a covered expense if breast size is contributing to documented physical health conditions and a minimum of 350 grams per breast is removed.
7. **Chelation therapy.** Charges for chelation therapy, except to treat heavy metal poisoning.
8. **Contraceptives.** Charges for contraceptive devices, including the placement or removal of a contraceptive device.
9. **Corrective footwear.** Orthopedic shoes or corrective footwear devices not specifically designed or molded.
10. **Cosmetic services.** Cosmetic surgery, treatment, or related hospital admissions, unless made necessary:
 - by an accidental injury;
 - for correction of congenital deformity when necessary to perform a normal body function; and/or
 - for reconstructive surgery as necessary for the prompt treatment of a diseased condition.
11. **Court ordered treatment.** Charges resulting from court ordered or recommended alcohol, substance abuse or psychological treatment or evaluation.
12. **Custodial care.** Custodial care, which is care whose primary purpose is to meet personal rather than medical needs and which can be provided by persons with no special medical skills or training. Such care includes, but is not limited to: helping a patient walk, get in or out of bed, and take normally self-administered medicine. The Benefit Services Administrator shall determine, based on reasonable medical evidence, whether care is custodial.
13. **Dental.** Charges for or in connection with treatment of teeth or periodontium or treatment of periodontal or periapical disease or any condition (other than a malignant tumor) involving teeth or surrounding tissue, except as provided in Section 5.30.
14. **Dental implants.** Charges for dental implants.
15. **Developmental delays.** Charges for treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy, and any related diagnostic testing.
16. **Discounts.** Preferred Provider discount amounts or "cash discounts".

17. **Educational or vocational testing.** Services for educational or vocational testing or training.
18. **Excess charges.** The portion of a charge for services and supplies in excess of the Maximum Allowable Fee as determined by the geographical region.
19. **Exercise.** Charges for exercise equipment or health club memberships.
20. **Experimental or Investigational.** Any treatment of a disability, injury, or disease which is not widely used, generally accepted treatment for the disability, injury or disease, and which treatment, surgery or drug is considered experimental or investigational as defined in *Article IX*.
21. **Eyelid and Eyebrow Surgery.** Charges for Lower Lid Blepharoplasty, Upper Lid Blepharoplasty and Blepharoptosis (upper eyelid surgery), or Brow Ptosis (eyebrow lift); unless preoperative formal visual tests indicate correctable impairment of central visual acuity or peripheral vision and a preoperative photograph demonstrate the impingement of the lid margin on the pupil.
22. **Failure to keep appointments.** Charges for failure to keep scheduled appointments.
23. **Felonious Acts.** Charges resulting from or caused during the commission of a felony.
24. **Food.** Food, food supplements, or special diets and liquids unless provided while the covered person is confined in a hospital or for the treatment of phenylketonuria (PKU).
25. **Foot care.** Services or supplies for the removal of corns or calluses or for the trimming of toenails, unless the charges are for the partial or complete removal of nail roots or necessary in the treatment of a metabolic or peripheral-vascular disease.
26. **Foreign medical care.** Charges incurred outside the United States if the participant or dependent traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies.
27. **Government provided services.** Services provided by the United States government, any state government, or any government outside the United States in which the participant or dependent is entitled to receive benefits. An exception to this exclusion applies for services provided by the United States government which can be billed to the employee's plan under the Consolidated Omnibus Budget Reconciliation Act of 1985.
28. **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. An exception to this exclusion is a wig for hair loss due to administration of cytotoxic agents.
29. **Hearing aids and exams.** Hearing aids or examinations for prescriptions or fitting of hearing aids.
30. **Hypnotism.** Charges for hypnotism.
31. **Infertility.** Charges related to or in connection with the treatment of infertility, sterility, artificial insemination, or in-vitro fertilization. "Treatment of infertility" means the use of methods which do not correct the inability to conceive, but create the conditions for the individual to conceive by stimulating the individual's natural reproductive system or by implantation.
32. **Liposuction.** Charges for liposuction.
33. **Mailing expenses.** Mailing and/or shipping charges.
34. **Marital counseling.** Charges for marital counseling.
35. **Massage therapy.** Charges for massage therapy performed by a massage therapist.

36. **No charge.** Charges that you are not legally required to pay for or for charges which would not have been made if this coverage had not existed.
37. **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician.
38. **Nonprescription items.** Nonprescription medicines, vitamins, nutrients, and food supplements, even if prescribed or administered by a physician.
39. **Not appropriate.** Charges that are not appropriate in the treatment of the diagnosed sickness or injury.
40. **Not medically necessary.** Charges incurred in connection with services and supplies which are not necessary for treatment of an active illness or injury, except as specifically provided for in this Plan.
41. **Obesity.** Charges for the treatment of obesity (except morbid obesity), weight control or diet. Surgical treatment of morbid obesity is a covered expense and is limited to one surgical procedure per lifetime. See *Article IX* for definition of Morbid Obesity. Non surgical treatment of morbid obesity is not covered by this Plan.
42. **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.
43. **OTC Prescriptions.** Over-the-counter (OTC) prescriptions.
44. **Personal comfort or convenience items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, home spas, modifications to motor vehicles and/or homes to accommodate a disability, electric heating units, orthopedic mattresses, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.
45. **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.
46. **Providing medical information.** Charges for completion of claim forms or providing medical information necessary to determine coverage.
47. **Psychiatric treatment provider.** Professional psychiatric treatment by anyone other than a physician as defined herein.
48. **Relative giving services.** Charges for services rendered by a physician, nurse or licensed therapist who is a close relative of the participant, or resides in the same household as the participant.
49. **Routine services.** Routine services such as, but not limited to, routine physical exams, routine immunizations, premarital exams, pediatric care, urinalysis, exams and screening procedures for family history, and pregnancy test except as specifically provided for in this Plan.
50. **Sales tax.**
51. **Self-Inflicted.** Charges for suicide or treatment of any intentionally self-inflicted injury, unless the injury is the result of a medical condition.
52. **Services before or after coverage.** Charges incurred prior to the effective date of coverage, or after the termination date of coverage.

53. **Sex changes.** Care, services or treatment for non-congenital transsexuals, gender dysphasia or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
54. **Smoking cessation.** Charges for the treatment of nicotine use or addiction.
55. **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
56. **Telephone consultations.** Charges for telephone consultations.
57. **Third party liability.** Charges in connection with an injury to the extent payment is the responsibility of a third party. The Plan will pay benefits if the participant or dependent agrees, in writing, to repay such benefits to the extent payment is made to him by the person responsible for the injury (as a settlement, judgment or in any other way). See Section 10.11, *Right of Subrogation And Reimbursement*.
58. **Travel or accommodations.** Travel, whether or not recommended by a physician, except as stated in Sections 5.03 and 5.26.
59. **Unwanted hair.** Care and treatment for unwanted facial hair.
60. **Vision care.** Eyeglasses, contact lenses, eye refractions, or surgery to correct eye refractions (including but not limited to radial keratotomy and keratomileusis).
61. **Visual Training or Orthoptics.** Charges for visual training or orthoptics.
62. **War.** Treatment made necessary by war, declared or undeclared, or any act of war.
63. **Well-Child Care.** Charges for well-child care, including immunizations and the usual, ordinary, and routine care of a newborn, except as provided in Sections 5.27 and 5.31. (Nursery charges, including physician services, for newborn children are covered as any other eligible expense.)
64. **Worker's Compensation.** Services covered by or for which the participant or dependent is entitled to benefits under any Worker's Compensation or similar law.

ARTICLE IX

Definitions

ACTIVE DUTY

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

Actively-at-work means an employee must work for his employer at his usual place of work or such other place or places as required by his employer in the course of such work for the full number of hours and full rate of pay, as set by the employment practices of this employer.

BENEFIT SERVICES ADMINISTRATOR

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. The Benefit Services Administrator for this Plan is First Administrators, Inc.

BIOLOGICALLY-BASED MENTAL ILLNESS

Biologically Based Mental Illness means schizophrenia and other psychotic disorders; bipolar disorder; major depression; and obsessive-compulsive disorder.

BUSINESS ASSOCIATE

The term "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.

CLOSE RELATIVE

The term "Close Relative" includes the spouse, mother, father, sister, brother, child or in-laws of the participant.

CONCURRENT REVIEW

Utilization Review conducted during a patient's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting.

CONTINGENCY OPERATION

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.

COSMETIC SERVICES

The term "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 EXPENSES

Covered Expenses mean expenses incurred which are dentally/medically necessary that are not specifically excluded from coverage elsewhere in this Plan.

COVERED SERVICEMEMBER

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.

CREDITABLE COVERAGE

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.

DEPENDENT

The term dependent means the spouse of the participant, if not legally separated or divorced, and unmarried

- A. natural children;
- B. stepchildren;
- C. legally adopted children;
- D. foster children;

of the participant or spouse who are dependent upon the participant for support and for whom an application for coverage hereunder has been submitted to the Plan as required. Such child shall remain a dependent hereunder until: (A) marriage; or (B) when he attains the age specified in the Schedule of Benefits; or (C) receives less than 50% of his/her financial support from the parent participant or is not claimed on the parent participant income tax return as a dependent.

When an application for coverage hereunder has been submitted to the Plan as required, for any participant's unmarried natural child, stepchild, or legally adopted child for whom the parent participant or his current spouse is required by court decree or Qualified Medical Child Support Order (QMCSO) to provide healthcare coverage, such child shall remain a dependent under this Plan until he attains the age specified in the court decree or order.

"Stepchild" shall mean any natural or adopted child of any employee's current spouse, and any natural or adopted child of a former spouse of the employee living in the employee's home in a familial relationship if the natural parents of that natural or adopted child are both deceased.

"Adopted Child" shall mean any child taken into the participant's family legally and for whom the participant is legally responsible.

"Foster Child" shall mean any child legally placed in the participant's custody who is receiving parental care from the participant and for whom the participant is legally responsible to provide medical care.

In the event a child who is a dependent as defined herein is incapable of self-sustaining employment by reason of a permanent handicapping mental or physical disability and chiefly dependent upon the participant for support and maintenance beginning prior to the end of the calendar year in which he turns the age specified in the Schedule of Benefits, coverage will continue as a dependent until the participant, for any reason, discontinues his coverage hereunder; he is no longer considered an eligible participant; the Plan is canceled; or the disability no longer exists as determined by the Plan. Satisfactory evidence of such disability and dependency will be required by the Benefit Services Administrator. Such evidence must be received within 31 days of the dependent's normal termination date, with a request from the Plan participant for coverage to continue.

In the event a dependent child 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 Section 1.05 of the Plan.

Eligible dependents (see *Dependent Unmarried Child Maximum Age* in the Schedule of Benefits) enrolled fulltime in an accredited college or university, must submit proof of enrollment. The student must be considered fulltime as defined by the institution in which the dependent is enrolled. A letter from the registrar indicating proof of fulltime enrollment must be submitted every semester or quarter. If you are considered a fulltime student at the beginning of a semester, you will be considered an eligible dependent for the remainder of that semester, as long as you meet all other criteria established by the Plan.

In the event an eligible dependent child, over the age of 19, discontinues as a full-time student, he will no longer have coverage and will have the option to purchase individual coverage as stated in the Schedule of Benefits. If that dependent has completed the spring semester/quarter as a full-time student, he will have coverage through September 1 of the current year, and may elect continuation thereafter.

A previously ineligible Dependent who becomes a full-time student at a recognized educational institution may be enrolled as a Dependent within 31 days after the first day of class of the term for which the Dependent is enrolled. Proof of enrollment as a full-time student from the educational institution must be provided to the Benefit Services Administrator.

DEVELOPMENTAL DELAYS

The term "Developmental Delays" means the lack of normal physiological development in motor, language, social, adaptive and /or cognitive function.

DURABLE MEDICAL EQUIPMENT

"Durable Medical Equipment" shall mean equipment which:

- A. can withstand repeated use; i.e.; could normally be rented, and used by successive patients, and
- B. is primarily and customarily used to serve a medical purpose, and
- C. generally is not useful to a person in the absence of an illness or injury, and
- D. is appropriate for use in the home.

EFFECTIVE DATE

The effective date shall mean the first day this Plan was in effect as shown in this Summary Plan Description. As to the individual, it is the first day that benefits under this Plan would be in effect, after satisfaction of the waiting period and any other provisions or limitations contained herein.

EMERGENCY SERVICES

The term "Emergency Services" shall mean emergency care provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate attention could reasonably be expected to result in:

- A. Placing the patient's health in serious jeopardy;
- B. Serious impairment to bodily functions; or
- C. Serious dysfunction of any bodily organ or part.

EMPLOYEE

A person directly involved in the regular business of and compensated for services by the Plan Administrator and who is regularly scheduled to work not less than the hours per week shown in the eligibility section of this Plan.

EXPERIMENTAL OR INVESTIGATIONAL

Experimental or Investigational means 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.

GENDER

Whenever a personal pronoun in the masculine gender is used, it shall include the feminine also, unless the context clearly indicates the contrary.

HIPAA

The term "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 Public Law 104-191).

HOME HEALTH CARE AGENCY

The term "Home Health Care Agency" means a public or private agency or organization approved by Medicare that specializes in providing medical care and treatment in the home.

HOSPITAL

An institution which, for compensation from its patients and on an inpatient basis, is primarily engaged in providing:

- diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons; or
- rehabilitation services for the rehabilitation of injured, disabled, or sick persons

by or under the supervision of a staff of physicians who are duly licensed to practice medicine, and which continuously provides 24-hour-a-day nursing services by registered graduate nurses. It is not, other than incidentally, a nursing home, a place for rest, or for the aged.

INJURY

The term "injury" means bodily injury that is caused by accidental means by an event that is sudden and not foreseen, and is exact as to time and place which results in damage to the Individual's body from an external force or contact.

LIFETIME

The term "lifetime" means the period of time a person is actually covered 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.

MAXIMUM ALLOWABLE FEE

Maximum Allowable Fee means an amount established, using various methodologies, for covered services and supplies. The settlement amount is based on the lesser of the covered charge for a service or supply or the maximum allowable fee.

Information regarding the calculation and determination of the maximum allowable fee is available to the participant. Upon receiving the participant's request for such information, First Administrators, Inc. or the participant's group health plan sponsor will provide the following:

- the frequency of the determination of the maximum allowable fee;
- a general description of the methodology used to determine the maximum allowable fee, including geographic locations; and

- the percentile that determines the maximum benefit that will be paid for any procedure, if the maximum allowable fee is determined by taking a sample of fees submitted on actual claims and then determining the benefit by selecting a percentile of those fees.

MEDICALLY NECESSARY OR MEDICAL NECESSITY

A service or supply which is **necessary** for the diagnosis, care, or treatment of the physical or mental condition involved. It must be widely accepted professionally as **effective, appropriate, and essential** based upon recognized standards of the health care specialty involved and the American Medical Association or Food and Drug Administration.

MEDICARE

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.

MORBID OBESITY

The term "Morbid Obesity" shall mean all of the following are true:

- Your weight is more than 150% over standard weight for height, sex, and age;
- You have been considered morbidly obese by a physician for at least five years; and
- Non-surgical methods of weight loss have been supervised by a physician for at least three years without success.

NEXT OF KIN

Next of kin means the nearest blood relative or individual.

PARTICIPANT

An employee who has satisfied the waiting period established in this Plan, who has met the actively at work clause established by the Plan and who has enrolled for coverage by completing enrollment forms provided by the Plan Administrator (see Section 1.01 for eligibility details) or a person who has elected continuation of coverage under the provisions of the Plan. Participant coverage is restricted by the limitations set forth in the Plan Pre-existing Condition Exclusion Period, Section 1.09.

PHYSICIAN

The term physician means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed without limitation to practice medicine, surgery or obstetrics at the time and place service is rendered. This definition also includes physician's assistants, certified nurse practitioners, certified surgical technologists, and registered nurse-midwives, when working directly for a doctor of medicine. For services covered by this Plan and for no other purpose, doctors of dental surgery, doctors of dental medicine, doctors of podiatry, optometrists, and chiropractors are deemed to be physicians when acting within the scope of their license for services covered by this Plan. Registered Physical, Occupational, Respiratory, and Speech Therapists, Psychologists, and Social Workers licensed under state law when providing a covered service will be covered under this definition.

PLAN

The term "Plan" whenever used herein without qualification shall mean the document adopted by the Plan Administrator.

PLAN ADMINISTRATOR

The person or group responsible for the day-to-day functions and management of the Plan. The Plan Administrator may retain persons or firms to process claims and perform other Plan-connected services. The Plan Administrator is the Employer unless otherwise designated.

PLAN SPONSOR

The term "Plan Sponsor" means an entity that sponsors a health plan. This can be an employer, a union or some other entity.

PRE-EXISTING CONDITION

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.

PREGNANCY

The term "Pregnancy" means the condition of being pregnant and all conditions and/or complications resulting therefrom.

PRIVATE DUTY NURSING

The term "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.

PROSPECTIVE REVIEW

Utilization Review conducted prior to an admission or the provision of a health care service or a course of treatment in accordance with a healthcare plan's requirement that the health care service or course of treatment, in whole or in part, be approved prior to admission or the service.

PROTECTED HEALTH INFORMATION (PHI)

The term "Protected Health Information (PHI)" means individually identifiable health information (any health information that can be tied back to an individual).

RETROSPECTIVE REVIEW

Any review of a request for a benefit that is not a prospective review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication for payment.

ROOM AND BOARD CHARGES

The institution's charges for room and board and its charges for other necessary institutional services and supplies, made regularly at a daily or weekly rate as a condition of occupancy of the type of accommodations occupied.

SEMI-PRIVATE RATE

The daily room and board charge which an institution applies to the greatest number of beds in its semi-private rooms containing 2 or more beds. If the institution has no semi-private rooms, the semi-private rate will be the daily room and board rate most commonly charged by that institution.

SICKNESS

The term "sickness" means an illness causing loss commencing while this Plan is in force for the covered person. Sickness shall also be deemed to include disability caused or contributed by pregnancy, miscarriage, childbirth and recovery therefrom. It shall only mean sickness or disease which requires treatment by a physician.

SKILLED NURSING FACILITY

An institution, or a distinct part of an institution meeting all of the following tests:

- It is licensed to provide and is engaged in providing, on an inpatient basis, for persons convalescing from injury or disease, professional nursing services rendered by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered graduate nurse, physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities.
- Its services are provided for compensation from its patients and which patients are under the full-time supervision of a physician or registered graduate nurse (R.N.).
- It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time registered graduate nurse (R.N.).
- It maintains a complete medical record on each patient.
- It has an effective Utilization Review plan.

It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, custodial or educational care, or care of mental disorders.

SPINAL MANIPULATION OR CHIROPRACTIC CARE

The term "Spinal Manipulation" or "Chiropractic Care" means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

SPOUSE

The term "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.

SURGICAL PROCEDURE

A surgical procedure means cutting, suturing, treating burns, correcting a fracture, reducing a dislocation, manipulating a joint under general anesthesia, electrocauterizing, tapping (paracentesis), applying plaster casts, administering pneumothorax, endoscopy or injecting sclerosing solution.

TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION

Temporomandibular joint (TMJ) dysfunction is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint.

TOTAL DISABILITY

The terms "total disability" and "totally disabled" mean:

- A. participant - his inability to engage, as a result of accident or illness, in his normal occupation with the employer,
- B. dependent - his inability to perform the usual and customary duties or activities of a person in good health and of the same age and sex.

WAITING PERIOD

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.

ARTICLE X

General Information

S10.01 PROCEDURES FOR FILING A CLAIM

Whenever you obtain healthcare services, you should present your healthcare identification card. Most physicians, hospitals, clinics, and pharmacies will file claims for you. Claims should be submitted to the address indicated on the back of your identification card.

This Plan participates in a preferred provider network. Claims are submitted to the network for repricing. After the preferred provider network has repriced the claim, claims are sent to the Benefit Services Administrator for processing. Claims will be considered filed with the Benefit Services Administrator when a completed UB-92 claim form, HCFA claim form, or itemized bill (as described below) is received or when the repriced claim form has been received from the preferred provider network.

If the participant receives services from a health care provider who does not file claims for you, you will need to file the claim directly with the Benefit Services Administrator. Use a separate claim form for each member of your family. **You must complete all sections of the claim form.** A copy of the itemized statement prepared by your health care provider should be attached to the claim form. An itemized statement prepared by your health care provider must contain all information requested below in order for us to consider your request for benefits as a claim for processing. The Benefit Services Administrator cannot accept statements you prepare, un-itemized cash register receipts, receipt of payment notices, or balance due notices. The itemized statement must be on the health care provider's stationery and include:

- health care provider's identification: full name, address, tax or license ID numbers and provider numbers;
- patient information: first and last name, date of birth, gender, relationship to insured;
- participant information: first and last name, address, ID number;
- group or Plan number;
- date(s) of service;
- place of service: office, hospital, etc.;
- for inpatient claims: admission date, patient status, attending physician ID;
- injury or illness (if applicable): date and diagnosis with appropriate code;
- charge for each service;
- description of each service with appropriate code; and
- days or units of service.

If your claim results from an accident, it is important to know when, how and where your accident, illness or disability began, especially if it is job or auto related.

If you and/or your covered dependents are covered under more than one healthcare plan (including Medicare), and the other plan is primary (as determined by Section 10.10, *Coordination of Benefits*), claims should be submitted to the other plan first. Claims can then be submitted to this Plan, with an Explanation of Benefits from the primary plan attached to the itemized statement. Questions on the claim form regarding other coverage you or your dependents are eligible for must be answered.

If you submit a claim for a dependent enrolled fulltime in an accredited college or university, you must submit proof of enrollment. A letter from the registrar indicating proof of fulltime enrollment must be submitted every semester or quarter.

Sign the claim form and send it to the address on the top of the form. You should keep a copy of the claim for your records because no part of it can be returned to you. You should follow the same procedure for filing a claim for services received in-state or out-of-state.

If the participant requires medical services while traveling outside the United States, the following procedures apply:

1. Pay the health care provider at the time of service, preferably with a credit card;
2. Request an itemized statement prepared by the health care provider;
3. Submit a completed claim form, with the itemized statement and credit card bill attached (the credit card bill should show the applicable monetary exchange rate), to the Benefit Services Administrator.

If you are a new participant in this Plan, the Pre-Existing Condition Exclusion Period outlined in Section 1.09, including the right to demonstrate Creditable Coverage, will apply. In the absence of prior Creditable Coverage, a pre-existing condition investigation will be completed before claims will be processed.

Claims must be filed within 12 months of the incurred date to be covered under the Plan. A claim incurred more than 12 months prior to filing such claim will be denied.

If the participant needs a claim form or has any questions after reading this section, please contact employer or the Benefit Services Administrator.

If your provider of health care services needs information for electronic filing of claims, please have them call the number on the back of your identification card. Claims are considered received on the day First Administrators, Inc. receives them from the clearing house.

S10.02 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 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 healthcare 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 \$1,000.00 per calendar year.

S10.03 APPEALING A CLAIM

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

For appeals involving a decision made by your Utilization Review Company as outlined in Section 3.00, *Cost Containment Programs*, please contact the Utilization Review Company listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card.

First Level Appeal

You have 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:

- Medical necessity;
- Appropriateness of service, including level or effectiveness of treatment;
- Place of service;
- Experimental or investigational treatment;
- Contract limitation;
- Eligibility for coverage; or
- Concurrent review not involving an urgent care request.

You or your authorized representative may request a first level appeal by submitting a written grievance within 180 days after the date you were notified of an adverse determination.

Send your written grievance for a first level review to:

For appeals involving a decision made by your Utilization Review Company as outlined in Section 3.00, *Cost Containment Programs*, please contact the Utilization Review Company at the telephone number listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card.

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 your appeal request, you or your authorized representative will be sent a letter specifying the name of the person, address and phone number where the review will be conducted. You have 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 your 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, you or your authorized representative will be notified of the decision within 60 days after receipt of your grievance. For first level appeals regarding pre-service issues, you or your authorized representative will be notified of the decision within 30 days after receipt of your grievance. The decision of a first level appeal is subject to a second level appeal/voluntary review as outlined below.

Expedited Review

If your first level appeal involves a medically urgent situation or concurrent review urgent care request, you or your 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, your benefits will continue without liability in accordance with the terms of your eligible benefits until you are notified of the expedited review decision. If the expedited review decision results in the termination of benefits, your 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 decision made by your Utilization Review Company as outlined in Section 3.00, *Cost Containment Programs*, please contact the Utilization Review Company at the telephone number listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card.

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

You also have 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:

- Availability, delivery, or quality of health services; or
- Claim processing or payment.

You or your authorized representative may request a standard review by submitting a written grievance within 180 days after the date you were notified of a decision not involving an adverse determination.

For appeals involving a decision made by your Utilization Review Company as outlined in Section 3.00, *Cost Containment Programs*, please contact the Utilization Review Company at the telephone number listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card.

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 your standard review request, you or your authorized representative will be sent a letter specifying the name of unit, address and phone number where the review will be conducted. You have 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 standard review will be conducted by someone not previously involved in your case and not by a subordinate of anyone previously involved. 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.

You or your authorized representative will be notified of the decision within 20 working days after receipt of your standard review request. The decision of a standard review is subject to a second level appeal/voluntary review as outlined below.

Second Level Appeal/Voluntary Review

If you are not satisfied with the resolution of a first level appeal or standard review, you or your authorized representative have the right to make an appeal to the review committee.

You or your 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.

Send your written grievance for a second level appeal/voluntary review to:

For appeals involving a decision made by your Utilization Review Company as outlined in Section 3.00, *Cost Containment Programs*, please contact the Utilization Review Company at the telephone number listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card to obtain the address where the appeal can be sent.

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

Upon receiving your request for a second level appeal/voluntary review you will be sent a letter notifying you of the date of the review committee meeting. In addition, you will also be advised of your rights to:

- 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;
- submit written comments, documents, records, and other materials relating to the appeal to the review committee;
- receive, upon request and free of charge, copies of all relevant documentation used during the appeal;
- present your case to the review committee;
- ask questions of any representative on the review committee; and
- be assisted or represented by an individual of your or your authorized representative's choice.

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

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

If you or your authorized representative do not request the opportunity to appear in person before the review committee, the review committee will issue a decision within 45 days of your notice not to appear or within 45 days after your opportunity to request a personal appearance expires, whichever is earlier.

The information contained in this section is a summary of the appeal procedures. A copy of the complete appeal procedure is available, free of charge, to you or your authorized representative by calling:

The Utilization Review Company at the telephone number listed on Page 1, *Plan Specifications*, of this booklet or on the front of your identification card.

The Benefit Services Administrator at:

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

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

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

S10.04 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 the 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.

S10.05 SUMMARY PLAN DESCRIPTION

The Plan Administrator will make available to each participant covered under the Plan an individual booklet which shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the participant.

S10.06 PLAN TERMINATION

The Plan Administrator may terminate the Plan at any time. Upon termination the rights of participants to benefits are limited to claims incurred and due up to the date of termination. Any termination of the Plan will be communicated to participants.

S10.07 ASSIGNMENT OF PAYMENT

The Plan will assign all benefits accruing under this Plan to the hospital, physician or other provider of service. Assignment shall not be binding on the Plan if the Benefit Services Administrator is notified in writing that such claim has been previously paid.

S10.08 AMENDMENT OF SUMMARY PLAN DESCRIPTION

The Plan Administrator may modify or amend the Plan from time to time at its sole discretion and such amendments or modifications which affect covered participants will be communicated to participants.

S10.09 NOTICE OF CLAIM

You should provide notice of claim and proof of loss (a claim for eligible expenses) to the Benefit Services Administrator within 90 days following the date any sickness or disability commences.

S10.10 COORDINATION OF BENEFITS

Coordination of Benefits rules in group health plans establish guidelines to determine the order and level of reimbursement when a plan beneficiary is covered under more than one health care plan (including Medicare). In other words, Coordination of Benefits rules tell you which plan pays first, which plan pays second, and how much in total both plans pay. This provision shall not apply, however, to benefits obtained by a participant or dependent from an individual medical insurance policy under which such participant or dependent is entitled as a named person.

Definitions

The term "allowable expense" shall mean a healthcare service or expense, including deductibles, coinsurance, or co-payments, that is covered in full or in part by any of the plans covering the person for whom the claim is made. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Expenses that are not allowable include the following:

1. If a covered person is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room, (unless the patient's stay in the private hospital room is medically necessary in terms of generally accepted medical practice, or one of the plans routinely provides for private hospital rooms) is not an allowable expense;

2. If a person is covered by two or more plans that compute the benefit payments on the basis of Maximum Allowable fees, any amount in excess of the highest of the Maximum Allowable fee for a specified benefit is not an allowable expense;
3. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense; or
4. If a person is covered by one plan that calculates its benefits or services on the basis of Maximum Allowable fees and another plan provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans.

The term "plan" or "benefit plan" means this Plan or any one of the following plans:

1. Group or blanket benefit plans, including Health Maintenance Organizations.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes Medicare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
6. No Fault Vehicle Insurance, by whatever name it is called, when not prohibited by law.

The term "order of benefits determination" shall mean the method for ascertaining the order in which the Plan renders payment thereunder. The principle applies when another plan has a Coordination of Benefits provision.

Application

Under the order of benefits determination method, the plan which is obligated to pay its benefits first is known as the "primary" plan. The plan which is obligated to pay additional benefits for allowable expenses not paid by the primary plan is known as the "secondary" plan. Where another plan contains a Coordination of Benefits provision, the following order of benefits determination will establish the responsibility for payment thereunder:

1. Non-Dependent or Dependent. In general, the plan covering the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary, and the plan covering the person as a dependent is the secondary payer. However, if the retiree is a Medicare beneficiary, the order of benefits is reversed, and the order of benefit determination is as follows:
 - the plan covering the person as a dependent;
 - Medicare;
 - the plan covering the person as a retiree.
2. Child Covered Under More Than One Plan (The Birthday Rule). The primary plan is the plan of the parent whose birthday is earlier in the year (month and day, not year), if the parents are married or if a court order awards joint custody without specifying which parent has responsibility for providing health care coverage.

If a court order specifies that one parent is responsible for health coverage, then the plan of that parent will be primary. If the parent with financial responsibility has no coverage for the child's health care expenses, but that parent's spouse does, the spouse's plan is primary.

If the parents are separated or divorced and there is no court order specifying that one parent is responsible for health coverage, the order of benefit determination is as follows:

- the plan of the custodial parent,
- the plan of the spouse of the custodial parent,
- the plan of the non-custodial parent,

- the plan of the spouse of the non-custodial parent.
3. Active or inactive employee. If an individual is covered under one plan as an active worker and another plan as a retired worker, the active worker plan is primary. However, if an individual is covered both as a retiree under one plan and as a dependent under a spouse's active employee plan, order of benefit determination is that the retiree plan pays first and the dependent plan pays second.
 4. Continuation Coverage. If a person has continuation coverage under the federal COBRA law or state continuation laws and also is covered under another group plan as an employee, member, subscriber, or retiree (or as that person's dependent), then the continuation coverage pays second.
 5. Longer or Shorter Length of Coverage. If the rules above do not determine the order of benefits, then the plan that covered the person for the longer period of time is primary.
 6. If none of the preceding rules determines the primary plan, allowable expenses should be shared equally between the plans.

As the primary plan, the Plan will provide payment in accordance with the provisions of this Plan.

As a secondary plan, the Plan will provide payment for allowable expenses and services of physicians, but only to the extent that payment for such hospital services and services of physicians are not provided by the primary plan or other secondary plans.

In no event will total payment by the Plan exceed the amount which would have been paid as primary plan, nor will this plan's payment, when combined with the primary plan, exceed 100% of total claims. The difference between the amount which the Plan would have been paid as primary plan and the amount which was actually paid as secondary plan through the application of the Coordination of Benefits provision on a given claim will accrue to the credit of the individual patient only for the remainder of the calendar year. It is, therefore, available in an amount not to exceed that which would have been payable by the Plan as primary plan, to pay for allowable expenses and services of physicians, subsequently incurred which may not be paid in full by the primary and secondary plans.

The Plan shall be considered to be the secondary plan when the other plan does not contain a Coordination of Benefits provision. The total payment by the Plan for hospital services and physicians' services shall not exceed the amount which would have been paid as a secondary plan.

Vehicle Coverage Limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the vehicle carrier. In no event will total payment by the Plan exceed the amount which would have been paid as primary plan, nor will this plan's payment, when combined with the primary plan, exceed 100% of total claims.

Subject to other applicable provisions of this Plan, the payment of medical expenses under the Plan resulting from a vehicle accident will depend upon the type of vehicle insurance law enacted by the state in which the participant is covered under the Plan. Depending upon the vehicle insurance law so enacted, the participant's or dependent's coverage under the Plan will be determined under one of three following provisions:

- A. Coordination Under Vehicle No-Fault Coverage. The Plan is secondary to any no-fault vehicle coverage. It is not intended to reduce the level of coverage that would otherwise be available through a no-fault vehicle insurance policy nor does it intend to be primary in order to reduce the premiums or cost of no-fault vehicle coverage.

If the participant or dependent incurs covered expenses as the result of a vehicle accident (either as a driver, passenger or pedestrian), the amount of covered expenses that the Plan will pay is limited to:

1. Any deductible under the vehicle coverage; and
2. Any co-payment under the vehicle coverage; and

3. Any expense properly excluded by the vehicle coverage that is a covered expense; and
4. Any expense that the Plan is required to pay by law.

An individual is considered to be covered under a vehicle insurance policy if he or she is either: (1) an owner or principal named insured of the policy; or (2) a family member of the person insured under the policy; or (3) a person who would be eligible for medical expense benefits under a vehicle insurance policy if this Plan did not exist.

- B. Coordination Under Financial Responsibility Law. The Plan is secondary to vehicle coverage or to any other party who may be liable for the covered person's medical expenses resulting from the vehicle accident.

If the participant's state has a "financial responsibility" law which does not allow the Plan to pay benefits as secondary or which does not allow the Plan to advance payments with the intent of subrogating or recovering the payment, the Plan may not pay any benefits related to a vehicle accident for the covered person or their dependents.

- C. Coordination Under Other Vehicle Liability Insurance. If the participant's state does not have a no-fault vehicle insurance law or a "financial responsibility" law, this Plan is secondary to their vehicle insurance coverage or to any other party who may be liable for the participant's or dependent's medical expenses resulting from the vehicle accident.

In the event the Plan makes payment to a participant or a dependent under any one of the three foregoing provisions, any and all such payments shall be subject, to the extent allowed by law, to the subrogation provisions of Section 10.11 hereafter.

To administer the Coordination of Benefits provision, this Plan has the right to:

1. provide or obtain data needed to determine the benefits payable under this provision; and
2. recover any sum paid above the amount that is required by this provision; and
3. repay any party for a payment made by that party, when the payment should have been made by this Plan.

S10.11 RIGHT OF SUBROGATION AND REIMBURSEMENT

Payment Condition

The Plan, in its sole discretion, may elect to conditionally advance payment of medical 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 Covered Persons, plan beneficiaries, and/or their dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

Covered Person(s), 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 Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) 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 Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

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

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to subrogate the Plan to 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 Covered Person(s) is entitled, regardless of how classified or characterized.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person(s) 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 Covered Person(s) 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 Covered Person(s) fails to file a claim or pursue damages against:

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

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) 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

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 Covered Person(s) 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 subrogation lien. The obligation 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 Covered Person(s)' 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 Covered Person(s), 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 Covered Person(s).

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

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 provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

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

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), 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

In the event that the Covered Person(s) 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

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

- 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;
- 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;
- to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
- to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- 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 Covered Person(s) 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 Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependant upon the Covered Person(s)' cooperation or adherence to these terms.

Offset

Failure by the Covered Person(s) 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 may be withheld until the Covered Person(s) satisfies his or her obligation.

Minor Status

In the event the Covered Person(s) 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

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

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.

S10.12 PERSONS ELIGIBLE FOR MEDICARE

For employers with 20 or more employees, active employees age 65 and over and their dependent spouses age 65 and over who are covered under this Plan are entitled to benefits under this Plan on the same basis as active employees and their dependent spouses under age 65. This Plan will pay as the primary plan to Medicare. If under 20 employees, Medicare is the primary plan.

For employers with 100 or more employees, this Plan will be the primary plan for totally disabled employees and totally disabled dependents who are covered under this Plan while entitled to Medicare disability benefits. If under 100 employees, Medicare is the primary plan.

For persons eligible for Medicare by reason of End Stage Renal Disease, this Plan shall be primary during the initial 30-month period (not including any waiting period established by Medicare). Thereafter, Medicare will be the primary plan.

The following applies to a non-employee individual who is covered under the Plan and also is eligible for Medicare. The payments under the Plan are determined as shown in the Schedule of Benefits.

The person will be assumed to have full Medicare coverage whether or not the individual has enrolled for the full coverage. If Medicare benefits are paid for expenses not covered under the Plan, they will not be used to determine benefits payable under the Plan. In cases of services and supplies which Medicare makes direct reimbursement to the provider, the amount of expenses and Medicare benefits will be determined on the basis of the Maximum Allowable Fee for the services and supplies.

Once the participant is a retired employee and the participant or his or her dependents become eligible for Medicare, the benefits covered by this Plan are ***automatically reduced*** by the benefits available to the Medicare-eligible person under Medicare regardless of whether or not the person eligible for Medicare enrolls for Medicare coverage. To avoid having to pay for Medicare-available benefits, it is important that the participant or his or her dependent enroll for Medicare coverage as soon as he or she becomes eligible.

If a dependent is eligible for Medicare and the active employee is not, this Plan will continue to be primary until the employee is retired and eligible for Medicare.

S10.13 FACILITY OF PAYMENT

In the event of your death or mental incompetence at a time when benefits remain unpaid, the Benefit Services Administrator will process payment for such benefits to the person or institution with whom the covered charges were incurred if the charges have not otherwise been paid.

S10.14 MISREPRESENTATION

Any material misrepresentation on the part of the Plan Administrator or the participant in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage null and void.

S10.15 FREE CHOICE OF PHYSICIAN

The participant and dependents shall have free choice of any licensed physician or surgeon, and the physician-patient relationship shall be the decision of the participant or dependent. An exception to this provision is that a relative of the participant or dependent shall not be an approved provider of health care, under this Plan, unless such provider is approved by the Plan Administrator or Benefit Services Administrator prior to the date of care.

S10.16 NOT LIABLE FOR ACTS OF HOSPITALS OR PHYSICIANS

Nothing contained herein shall confer upon a participant or dependent any claim right, or cause of action, either at law or at equity, against the Plan for the acts of any hospital in which he receives care, or for the acts of any physician from whom he receives service under this Plan.

S10.17 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.

S10.18 RIGHT OF RECOVERY

Whenever a claim payment has been made in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Plan, the Benefit Services Administrator shall have the right to recover such payments, to the extent of such excess, from among one or more of the following as the Benefit Services Administrator shall determine: any persons to, or for, or with respect to whom such payments were made, and/or any insurance companies and other organizations.

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.

S10.19 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.

S10.20 NONDISCRIMINATION STATEMENT

In addition, this Plan may not discriminate against you 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 cost-sharing amounts, co-pays or deductibles in return for adherence to programs of health promotion and disease prevention.

S10.21 PLAN ADMINISTRATION AND RIGHTS OF PARTICIPANTS

The Plan Administrator shall have full charge of the operation and management of the Plan.

As a participant in this Plan, you are entitled to the rights and protections set forth in this Plan. Upon request you may:

- A. Examine, without charge, at the Plan Administrator's office the Plan, and insurance contracts.
- B. Obtain copies of the Plan upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copy.

Your employer may not terminate your employment or discriminate against you to prevent you from obtaining a benefit. If you have questions about your benefits, you should contact your employer or the Plan Administrator.

The following is provided for your use if you desire additional information.

- A. Employer: Douglas School District #51-1
- B. Plan Identification Number: 20050
- C. Type of Plan: Medical Benefit Plan
- D. Plan Administrator: Douglas School District #51-1
400 Patriot Drive
Box Elder, SD 57719
- E. Plan Sponsor: Douglas School District #51-1
400 Patriot Drive
Box Elder, SD 57719

- F. Address for Legal Services: Business Manager
Douglas School District #51-1
400 Patriot Drive
Box Elder, SD 57719
- G. Plan Year: July 1 through June 30
- H. Plan Privacy Officer: Designated Representative by the Plan

S10.22 PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the Plan Administrator and any participant or to be a consideration for, or an inducement or condition of, the employment of any participant. Nothing in the Plan shall be deemed to give any participant the right to be retained in the service of the Plan Administrator or to interfere with the right of the Plan Administrator to discharge any employee at any time; provided however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be made by the Plan Administrator with the bargaining representative of any participants.

S10.25 FUNDING

This is a plan sponsor self-funded healthcare plan. The plan sponsor assumes the financial risk of healthcare coverage for the participants of this Plan. Healthcare costs are paid to the healthcare provider by the employer, rather than by an insurance company.

First Administrators, Inc. processes claims based on the guidelines of Section 10.01 "Procedures for Filing a Claim". The payment date of the claims is determined by the Plan Sponsor.

Contributions made to this Plan are used to pay claims and associated expenses of this Plan. The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each covered Participant.

If the participant's employer is unable to fund this Plan, the participant may be financially responsible for any incurred and unpaid claims. The Benefit Services Administrator assumes no financial liability.

S10.30 AUTHORIZED REPRESENTATIVE

You may authorize another person to represent you and with whom you want us to communicate with regard to specific claims or an appeal. This authorization must be in writing, signed by you, and include all the information required in our Designated Representative Form. A Designated Representative Form can be obtained by calling the Benefit Services Administrator. In a medically urgent situation, your treating health care practitioner may act as your authorized representative without completion of the Authorized Representative Form. An assignment of benefits, release of information, or other similar form that you may sign at the request of your health care provider does not make your health care provider a designated representative. You can revoke the designated representative at any time, and you can designate only one person as your representative at a time.

S10.35 PROTECTING PERSONAL HEALTH INFORMATION

Plan Sponsor's Certification of Compliance

The Employer is the Plan Sponsor of this Plan, unless participants have been notified, in writing, that another entity is the Plan Sponsor. This 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.

Purpose of Disclosure to Plan Sponsor

This Plan, any business associate servicing this Plan, or the Benefit Services Administrator will disclose protected health information to the Plan Sponsor only to permit the Plan Sponsor to administer this 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 this Plan” sections that follow.

Neither this Plan, nor the Benefit Services Administrator, nor any business associate servicing this 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 this Plan, nor 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 promptly report to this Plan, 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 this 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 this 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 This Plan

Certain individuals under the control of the Plan Sponsor may be given access to protected health information received from this Plan, a business associate servicing this Plan, or the Benefit Services Administrator. This class of employees will be identified by the Plan Sponsor to this 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 this 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 this 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 ("Protecting Personal Health Information"). The Plan Sponsor will promptly report such violation or noncompliance to this Plan, and will cooperate with this 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.