MyHealth Plan

A

STUDENT HEALTH INSURANCE BENEFIT PLAN

For the

State of South Dakota University System

Including:

Black Hills State University
Dakota State University
Northern State University
South Dakota School of Mines & Technology
South Dakota State University
The University of South Dakota
University Centers

Policy No: BOR1

Please Note: Your student health insurance coverage, offered by Avera Health Plans, may not meet the minimum standards required by the health care reform law for the restrictions on annual dollar limits. The annual dollar limits ensure that consumers have sufficient access to medical benefits throughout the annual term of the policy. Restrictions for annual dollar limits for group and individual health insurance coverage are $1.25 million for policy years before September 23, 2012; and $2 million for policy years beginning on or after September 23, 2012 but before January 1, 2014. Restrictions for annual dollar limits for student health insurance coverage are $100,000 for policy years before September 23, 2012, and $500,000 for policy years beginning on or after September 23, 2012, but before January 1, 2014. Your student health insurance coverage put an annual limit of: $500,000 per Plan Year. If you have any questions or concerns about this notice, contact Avera Health Plans. Be advised that you may be eligible for coverage under a group health plan of a parent’s employer or under a parent’s individual health insurance policy if you are under the age of 26. Contact the plan administrator of your parent’s employer plan or the parent’s individual health insurance issuer for more information.

- Covered Services - Read this document carefully for details on what services are covered.

- Reminder - Please keep this document as a general summary of your coverage. The Master Policy is on file with the South Dakota Board of Regents. This Master Policy contains all the provisions, Limitations, Exclusions and qualifications of your benefits, some of which may not be included in this document.

Plan Information -
- Offered by: The South Dakota Board of Regents
- Administered and Underwritten by: Avera Health Plans, Inc.

Contact Information -
Avera Health Plans, Inc.
3816 S Elmwood Avenue
Sioux Falls, SD 57105-6538
Phone: 1 (888) 322-2115
Fax: (605) 322-4540
www.AveraHealthPlans.com or
http://myhealth.sdbor.edu
Privacy Notice

Avera Health Plans Privacy Commitment
Avera Health Plans, Inc. does not sell or disclose any nonpublic personal information or nonpublic personal financial information about its subscribers or members to any companies not affiliated with Avera Health Plans, Inc., or to anyone else, except as required by law.

The Type of Information We Collect
Avera Health Plans, Inc. (“Avera Health Plans”) collects both nonpublic personal financial and nonpublic personal information about subscribers and members on application forms, through telephone requests, and through other forms of communication, such as letters. This information is needed to underwrite the policy, process claims, provide follow-up care with an insured and provide the optimum level of cost effective health care. “Nonpublic personal financial information” includes, for example, any list of individual names and street addresses that is not publicly available, social security numbers, policy account numbers, and salary information. “Nonpublic personal information” includes health information which can be a person’s past, present, or future physical, mental or behavioral health condition.

Avera Health Plans shall maintain the privacy, security and confidentiality of all nonpublic personal information transmitted or received through or maintained in connection with its contractual relationship in accordance with (i) all applicable statutes and regulations, including without limitation the applicable requirements, regulations and policies, and advisory opinions, from time to time amended, and (ii) the protocols, rules, policies and other requirements of accrediting agencies, licensors and authorities that are applicable to the operation of Avera Health Plans. Avera Health Plans restricts access to nonpublic personal financial and nonpublic personal information that it has obtained to those employees or affiliated companies under contract who need to know such information to provide timely and accurate claims processing, utilization management, quality control, and cost effective follow-up patient care. Avera Health Plans maintains policies and procedures that comply with federal regulations to guard your nonpublic personal and financial information from improper disclosures.

This Privacy Notice is available on Avera Health Plans website at www.AveraHealthPlans.com. If you have any questions about this Privacy Notice, call Avera Health Plans at (605) 322-4545 or contact us at 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105.

Notice of Privacy Practices
This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This notice will tell you how Avera Health Plans, Inc. (hereafter collectively referred to as the “Company”) may use and disclose protected health information. Protected health information means any health information that identifies you or for which there is a reasonable basis to believe the information can be used to identify you. In this notice, we’ll refer to protected health information simply as “medical information.”

This notice will describe your rights and the Company’s duties with respect to your medical information. In addition, it will describe how to file a complaint if you believe the Company has violated your privacy rights.

The Company May Use and Disclose Your Medical Information for the Following Reasons:

• For Treatment

To coordinate or manage health care and related services by both the Company and health care providers, your medical information may be disclosed to doctors, nurses, hospitals and other health facilities that become involved in your care. In addition, other health care providers may be given your medical information, such as medical consultants or specialists to which you have been referred. If the Company refers you to a physician, it also will contact that physician’s office and
provide medical information about you so the physician has information needed to provide quality services.

• For Payment

To process your claims for payment. This can include paying your health care providers, transactions with our reinsurance company, business associates that are contracted to perform or assist the Company, third party payors, or transactions with you. For example, the Company may need to get medical information from your health care provider to pay your bill or reimburse you for amounts you have paid. The Company also may need to provide medical information to a government program, such as Medicare or Medicaid, to determine your eligibility for a program.

• For Health Care Operations

Health care operations are necessary for the Company to maintain quality operations for our Members. For example, medical information about you may be used to offer optional treatments or pharmaceuticals. Medical information about you may be used to train Company staff. The Company may also use medical information to study ways to more efficiently manage our organization.

• How the Company Will Contact You

Unless you inform us otherwise in writing, the Company may contact you by either telephone or by mail at either your home or your office. At either location, the Company may leave messages for you on an answering machine or voice mail. If you want to request that the Company communicates to you in a certain way or at a certain location, see the Right to Receive Confidential Communications section of this notice.

• Appointment Reminders

To remind you about your appointments with our Case Management Nurses or other representatives.

• Treatment Alternatives

To contact you about treatment alternatives that may be of interest to you.

• Health-Related Benefits and Services

To contact you about health-related benefits and services that may be of interest to you.

• Individuals Involved in Your Care

The Company may disclose to a family member, other relative, a close personal friend or any other person identified by you, medical information that is directly relevant to that person’s involvement with your care or payment related to your care. The Company also may use or disclose medical information to notify, or assist in notifying, those persons of your location, general condition or death. If there is a family member, other relative, or close personal friend that you do not want the Company to disclose your medical information to, you must notify the Avera Health Plans Service Center at 1 (888) 322-2115 prior to any release of information occurring.

• Reports to Your Plan Sponsor
If you are in a self-insured plan, the Company will disclose to your designated plan sponsor representative(s) any of the following information upon request:

• Whether an individual who works for the plan sponsor, or that individual’s family member, is currently participating in the plan sponsor’s group health plan,

• When an individual who works for the plan sponsor, or that individual’s family member, enrolls or dis-enrolls from the plan sponsor’s group health plan, or

• Summary medical information will only be released upon request from the plan sponsor for the purposes of:
  • Obtaining a premium bid.
  • Modifying, amending or terminating the group health plan.

The only time the Company will disclose medical information to your plan sponsor is after the plan sponsor has contractually agreed to all HIPAA requirements and has its own HIPAA policies and procedures to protect your medical information.

• **Disaster Relief**

To disclose medical information about you to a public or private entity authorized by law or by its charter to assist in disaster relief efforts. This will be done to coordinate with those entities in notifying a family member, other relative, close personal friend or other person identified by you of your location, general condition or death.

• **Required by Law**

The Company may use or disclose medical information when we are required to do so by law.

• **Public Health Activities**

The Company may disclose medical information for public health activities and purposes. This includes reporting medical information to a public health authority that is authorized by law to collect or receive the information for purposes of preventing or controlling disease, or one that is authorized to receive reports of child abuse and neglect.

• **Victims of Abuse, Neglect or Domestic Violence**

To a government authority authorized by law to receive reports of abuse, neglect, or domestic violence, if the Company believes you are a victim of abuse, neglect, or domestic violence. This will occur to the extent the disclosure is:
  • Required by law,
  • Agreed to by you, or

Authorized by law and we believe the disclosure is necessary to prevent serious harm to you or to other potential victims; or, if you are incapacitated and certain other conditions are met, a law enforcement or other public official represents that immediate enforcement activity depends on the disclosure.

• **Health Oversight Activities**

To a health oversight agency for activities authorized by law, including audits, investigations, inspections, licensure or disciplinary actions. These and similar types of activities are necessary for appropriate oversight of the health care system, government benefit programs, and entities subject to various government regulations.

• **Judicial and Administrative Proceedings**

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In response to an order of the court or administrative tribunal. The Company also may disclose medical information in response to a subpoena, discovery request, or other legal process, but only if efforts have been made to tell you about the request or to obtain an order protecting the information to be disclosed.

• **Disclosures for Law Enforcement Purposes**

To law enforcement officials for law enforcement purposes:
- As required by law,
- In response to a court, grand jury or administrative order, warrant or subpoena,
- To identify or locate a suspect, fugitive, material witness or missing person,
- About an actual or suspected victim of a crime and that person agrees to the disclosure.
If we are unable to obtain that person’s agreement, in limited circumstances, the information may still be disclosed,
- To alert law enforcement officials to a death if we suspect the death may have resulted from criminal conduct,
- About crimes that occur at our facility,
- To report a crime in emergency circumstances.

• **Research**

Before the Company discloses medical information for research, the research will have been approved through a process that evaluates the needs of the research project with your need for privacy. The Company may, however, disclose medical information about you to a person who is preparing to conduct research, but no medical information will leave the Company during that person’s review of the information.

• **To Avert Serious Threat to Health or Safety**

If the Company believes the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public. The Company also may release information about you if it believes the disclosure is necessary for law enforcement authorities to identify or apprehend an individual who admitted participation in a violent crime or who is an escapee from a correctional institution or from lawful custody.

• **Military**

If you are a member of the Armed Forces, the Company may use and disclose your medical information for activities deemed necessary by the appropriate military command authorities to assure the proper execution of the military mission. The Company may also release information about foreign military personnel to the appropriate foreign military authority for the same purposes.

• **National Security and Intelligence**

To authorized federal officials for the purpose of national security activities or for the protection activities of certain U.S. or foreign federal employees as authorized by law.

• **Inmates; Persons in Custody**

To a correctional institution or law enforcement official having custody of you. The disclosure will be made if the disclosure is necessary: (a) to provide health care to you; (b) for the health and safety of others; or, (c) the safety, security and good order of the correctional institution.
• **Workers’ Compensation**

To the extent necessary to comply with workers’ compensation and similar laws that provide benefits for work-related injuries or illness without regard to fault.

• **Other Uses and Disclosures**

Other uses and disclosures will be made only with your written authorization. You may revoke such an authorization at any time by writing to: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105. However, if you revoke your authorization, it will not have any effect on actions already taken by us.

**Your Rights With Respect to Medical Information About You**

You have the following rights with respect to medical information that the Company maintains about you:

• **Right to Request Restrictions**

To request that the Company restrict the uses or disclosures of medical information about you to carry out treatment, payment, or health care operations. You also have the right to request that the Company restrict the uses or disclosures we make to:

- A family member, other relative, a close personal friend or any other person identified by you, or
- Public or private entities for disaster relief efforts. For example, you could ask that we not disclose medical information about you to your brother or sister.

To request a restriction, you may do so at the time you complete your consent form or at any other time. If you request a restriction after you have completed the initial consent form, you should do so in writing by mailing the request to: Avera Health Plans, Attn: Restriction Request, 3816 S. Elmwood Ave., Suite 100 Sioux Falls, SD 57105 and tell us:

- What information you want to limit,
- Whether you want to limit use or disclosure or both and
- To whom you want the limits to apply (for example, disclosures to your spouse).

The Company is not required to agree to any requested restriction. However, if the Company does agree, it will follow that restriction unless the information is needed to provide emergency treatment. Even if the Company agrees to a restriction, either you or the Company can later terminate the restriction.

• **Right to Receive Confidential Communications**

You have the right to request how or where the Company communicates to you. For example, you can ask that the Company only contact you by mail or at work. The Company will not require you to tell us why you are making the request. If you want to make a special request you must do so by sending your request in writing to: Avera Health Plans, Attn: Confidential Communications Request, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105. Your request must state how or where you can be contacted. The Company will accommodate your request. However, the Company may, when appropriate, require information from you concerning how payment will be handled.
• **Right to Inspect and Copy**

With a few very limited exceptions, such as psychotherapy notes, you have the right to inspect and obtain a copy of your medical information. For medical information that the Company has obtained from your provider(s), we ask that you make the request directly to the provider. To inspect or copy medical information about you that the Company has created, you must submit your request in writing to: Avera Health Plans, Attn: Inspect/Copy Request, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105. Your request should state specifically what medical information you want to inspect or copy. If you request a copy of the information, the Company may charge a fee for the costs of copying and, if you ask that it be mailed to you, the cost of mailing. The Company will act on your request within thirty (30) calendar days after it receives your request. If the Company grants your request, in whole or in part, it will inform you of its acceptance and provide access and copying. The Company may deny your request to inspect and copy if the medical information involved is:
- Psychotherapy notes,
- Information compiled in anticipation of, or use in, a civil, criminal or administrative action or proceeding.

If the Company denies your request, it will inform you of the basis for the denial, how you may have our denial reviewed, and how you may file a complaint. If you request a review of our denial, it will be conducted by a licensed health care professional designated by the Company who was not directly involved in the denial. The Company will comply with the outcome of that review.

• **Right to Amend**

You have the right to ask to have amended the medical information about you in the Company’s possession. This right is for as long as the Company maintains the medical information. For information that the Company has obtained from your provider(s) about you, the Company asks that you make the request to them. It is the Company’s policy that it does not amend information that it did not originate. To request an amendment, you must submit your request in writing to: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105. Your request must state the amendment desired and provide a reason in support of that amendment. The Company will act on your request within sixty (60) calendar days after it receives your request. If the Company grants your request, in whole or in part, it will inform you of its acceptance and provide access and copying. If the Company grants the request, in whole or in part, it will seek your identification and agreement to share the amendment with other entities. The Company also will make the appropriate amendment to the medical information by appending or otherwise providing a link to the amendment.

The Company may deny your request to amend medical information about you. The Company may deny your request if it is not in writing and does not provide a reason in support of the amendment. In addition, the Company may deny your request to amend medical information if it determines that the information:
- Was not created by the Company, unless the person or entity that created the information is no longer available to act on the requested amendment,
- Is not part of the medical information maintained by the Company,
- Would not be available for you to inspect or copy or
- Is accurate and complete.

If the Company denies your request, it will inform you of the basis for the denial. You will have the right to submit a statement disagreeing with our denial. Your statement may not exceed two pages. The Company may prepare a rebuttal to that statement. Your request for amendment, the Company’s denial of the request, your statement of disagreement, if any, and our rebuttal, if any, will then be appended to the medical information involved or otherwise linked to it. All of that will be included in your record.
then be included with any subsequent disclosure of the information, or, at our election, may include a summary of any of that information.

If you do not submit a statement of disagreement, you may ask that the Company include your request for amendment and our denial with any future disclosures of the information.

The Company will include your request for amendment and our denial (or a summary of that information) with any subsequent disclosure of the medical information involved. You also have the right to complain about the Company’s denial of your request.

• Right to an Accounting of Disclosures

You have the right to receive an accounting of your medical information disclosures. The accounting may be for up to six (6) years prior to the date on which you request the accounting, but not before April 14, 2003. Certain types of disclosures are not included in such an accounting:

• Disclosures to carry out treatment, payment and health care operations,
• Disclosures of your medical information made to you,
• Disclosures authorized by you,
• Disclosures for national security or intelligence purposes,
• Disclosures to correctional institutions or law enforcement officials.

Under certain circumstances your right to an accounting of disclosures may be suspended for disclosures to a health oversight agency or law enforcement official. To request an accounting of disclosures, you must submit your request in writing to: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105. Your request must state a time period for the disclosures. It may not be longer than six (6) years from the date we receive your request and may not include dates before April 14, 2003. The Company will act on your request within sixty (60) calendar days after it receives your request. Within that time, the Company will either provide the accounting of disclosures to you or give you a written statement of when the Company will provide the accounting and why the delay is necessary. There is no charge for the first accounting we provide to you in any twelve (12) month period. For additional accountings, the Company may charge you for the cost of providing the list.

If there will be a charge, the Company will notify you of the cost involved and give you an opportunity to withdraw or modify your request to avoid or reduce the fee.

• Right to a Copy of This Notice

You have the right to obtain a paper copy of the Company’s Notice of Privacy Practices at any time.

You may obtain a copy of the Company’s Notice of Privacy Practices on the Internet at www.AveraHealthPlans.com. To obtain a paper copy, mail a request to: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105 or call 1 (888) 322-2115.

The Company’s Duties

• Generally

The Company is required by law to maintain the privacy of medical information about you and to provide individuals with notice of our legal duties and privacy practices with respect to medical information. We are required to abide by the terms of our Notice of Privacy Practices in effect at the time.

• Our Right to Change Notice of Privacy Practices
The Company reserves the right to change this Notice of Privacy Practices. The Company reserves the right to make the new notice’s provisions effective for all medical information which is created or received by us, prior to the effective date of the new notice.

• **Availability of Notice of Privacy Practices**

A copy of the Company’s current Notice of Privacy Practices will be available at our corporate offices as well as on our web site, www.AveraHealthPlans.com. At any time, you may obtain a copy of the current Notice of Privacy Practices by mail at: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105 or call 1 (888) 322-2115.

• **Complaints**

You may complain to the Company and to the United States Secretary of Health and Human Services, Office of Civil Rights, if you believe your privacy rights have been violated. To file a complaint with the Company, contact: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105. All complaints should be submitted in writing. To find your HHS regional office, please call the Avera Health Plans Service Center at 1 (888) 322-2115. You will not be retaliated against for filing a complaint.

• **Questions and Information**

If you have any questions or want more information concerning this Notice of Privacy Practices, please contact by mail: Avera Health Plans, 3816 S. Elmwood Ave., Suite 100, Sioux Falls, SD 57105, or call (605) 322-4545 or toll-free at 1 (888) 322-2115.

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DEFINITIONS
Definitions are provided to help you understand terms used in this Policy.

BASIC COVERAGE means the Student Health Insurance Benefit Plan not including optional riders.

COINSURANCE means the percentage of the Preferred Allowance or the Usual and Customary charge for Covered Services which You must pay.

COMPANY means Avera Health Plans, Inc. Company is a corporation duly organized under the State of South Dakota that arranges for the provision of health care services to policyholders, with its principal place of business located in Sioux Falls, South Dakota.

CO-PAYMENT means a specified dollar amount which the Insured Person is required to pay for certain health care which is incurred on the date the service or supply is received. Co-payment may not be used to meet the Deductibles or Coinsurance limits. Co-payment must be paid to the Provider of services.

COVERED MEDICAL EXPENSES means reasonable charges which are:
1) made for services and supplies which are a Medically Necessary;
2) made for services included in the Schedule of Benefits;
3) not in excess of the maximum benefit amount payable per service as specified in the
4) Schedule of Benefits;
5) not in excess of Usual and Customary Charges;
6) in excess of the amount stated as a Deductible, if any, and;
7) made for services and supplies not excluded under the Policy.

Covered Medical Expenses will be considered incurred only: 1.) the covered services are provided; and 2.) a charge is made to You for such services.

**CREDITABLE COVERAGE** means benefits or coverage provided under:
1) Medicare or Medicaid;
2) An employer-based health insurance plan or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a health benefit plan;
3) An individual health insurance policy;
4) Chapter 55 of Title 10, United States Code which provides coverage for medical and dental care for Members and their Dependents and former members of the uniformed services;
5) A medical care program of the Indian Health Service or of a tribal organization;
6) A state health benefits risk pool;
7) A Federal Employee Health Benefit Plan (FEHBP);
8) A public health plan;
9) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504) (e);
10) A short-term limited-duration policy;
11) A college plan or;
12) A church plan

**DEDUCTIBLE** means the amount You must pay before payment of any benefit is made under the Policy. The Deductible will apply per Plan Year as specified in the Schedule of Benefits.

**DEPENDENT** means the spouse and children.

**DOMESTIC** means anyone that has a visa status that makes them eligible for South Dakota domicile and any United States citizen.

**EFFECTIVE DATE** means the date this Plan begins providing coverage for You.

**ELECTIVE SURGERY OR ELECTIVE TREATMENT** means those health care services or supplies that are not Medically Necessary.

**EXCLUSION** means benefits and/or services not covered under this Policy.
**HOSPITAL** means a facility recognized as a general, rehabilitation, psychiatric or specialized facility licensed as a Hospital by the proper authority of the state in which it is located.

The term “Hospital” specifically excludes rest homes, places which are primarily for the care of convalescents, nursing homes, skilled nursing care facilities, intermediate care facilities, halfway houses, health resorts, clinics, doctor’s offices, private homes, ambulatory surgery centers, residential or transitional living centers, or similar facilities.

**HOSPITAL ADMISSION** means confined in a Hospital by reason of an Injury or Sickness for which benefits are payable.

**INJURY** means bodily Injury incurred by You which is:
1) directly and independently caused by specific accidental contact with another body or object;
2) unrelated to any pathological, functional or structural disorder;
3) a source of loss;
4) treated by a Provider within 30 days after the date of accident; and
5) sustained while You are covered under this Policy.

**INVESTIGATIONAL, EXPERIMENTAL AND UNPROVEN** means services, supplies, drugs, treatments or technologies that have not met our evidence-based standards for safety and effectiveness as determined by our medical director, qualified party or other appointed entity. These evidence-based standards may include:

- Approval by an appropriate regulatory authority for general use,
- Scientific evidence from published, peer-reviewed medical literature establishing the safety and/or efficacy, patient selection criteria and proof of improved health outcomes,
- The service, supply or technology is at least as effective as existing alternatives,
- Health outcome improvements obtained in the study setting are reproducible in the community setting or
- Must not be subject to institutional review board oversight or approval.

Health services that are covered under the Policy and are not investigational, experimental or unproven are only available for coverage if they have also been determined to be medically necessary for that individual.

**LIMITATION** means a restriction or condition that affects the payment of benefits under the Plan.
**MASTER POLICY** means the contract between the Policyholder and the Company that governs and controls payment of benefits.

**MAXIMUM BENEFIT** means the maximum amount that We will pay toward the cost of a Covered Medical Expense as outlined within the Schedule of Benefits.

**MEDICAL EMERGENCY** means a medical condition manifesting itself by sudden and unexpected symptoms of sufficient severity which could not be foreseen by the Member, including but not limited to severe pain, that an ordinarily prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following:

1) Placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child in serious jeopardy;
2) Serious impairment to bodily function;
3) Serious dysfunction of any bodily organ or part;
4) Death; or
5) Left untreated or unattended until regular office hours would result in hospitalization or medical disability.

**MEDICALLY NECESSARY** means services which have been determined by the Company’s Chief Medical Officer to be of value in the care of a specific Member. To be Medically Necessary a service must:

1) Not be Investigational, experimental or unproven.
2) Be used to diagnose or treat Your condition caused by disease, Injury or congenital malformation.
3) Be provided at the most appropriate site and at the most appropriate level of service for Your medical condition.
4) On an ongoing basis, have a reasonable probability of:
   (a) Correcting a significant congenital malformation or disfigurement caused by disease or Injury.
   (b) Preventing significant disease or malformation.
   (c) Substantially improving a life-sustaining bodily function impaired by disease or Injury.
5) Not be provided solely to improve Your condition beyond normal variations in individual development and aging including:
   (a) Comfort measures in the absence of disease or Injury.
   (b) Improving physical appearance that is within normal individual variation.
6) Not be for the sole convenience of the Provider, You or Your family.

This Policy only provides payment for services, procedures or supplies that are Medically Necessary and meet the definition of Covered Medical Expenses. No
benefits will be paid for expenses which are determined to be not Medically Necessary.

MENTAL AND NERVOUS DISORDER means a Sickness that is a mental, emotional or behavioral disorder. Mental and Nervous Disorder does not mean a Biologically Based Mental Illness as defined in the Benefits for Biologically Based Mental Illness. If not excluded or defined elsewhere in the Policy, all diagnoses classified as a “Mental Disorder” according to the (International Classification of Diseases) are considered one Sickness.

NAMED INSURED PERSON means an eligible, registered student of the Policyholder, if:
1) the student is properly enrolled in the program; and
2) the appropriate premium for coverage has been paid.

NEGATIVE X-RAY means an X-ray that shows the absence of a fracture, pathology, or disease.

INFANT OR ADOPTED CHILD means any child born of an Insured Person or adopted by the Insured Person while the Insured Person is covered under this Policy. Routine, newborn care will be covered under this Policy for the first 31 days after birth.

OUT-OF-NETWORK PROVIDER means a provider who has not agreed to any prearranged fee schedules. You may have significant out-of-pocket expenses with these providers. Charges in excess of the insurance payment are your responsibility.

PHYSICIAN means any of the following licensed practitioners who perform a service payable under the Policy:

1) a doctor of medicine (MD or DO), osteopathy (DO), podiatry (DPM), or chiropractic (DC);
2) any other licensed practitioner, where required to cover by law, who:
   (a) is acting within the scope of the license; and
   (b) performs a service which is payable under the Policy

THERAPY means any form of the following:
- Physical or mechanical therapy
- Diathermy
- Ultra-sonic therapy
- Heat treatment in any form
- Manipulation or massage administered by a physician

PLAN means this document, the Student Health Insurance Plan for the State of South Dakota University System. The term “Policy” also means Plan.

PLAN YEAR means August 1 through July 31.
POLICYHOLDER means the South Dakota Board of Regents. Policyholder is an entity composed of universities in the state of South Dakota.

PRE-EXISTING CONDITION means any condition which is diagnosed, treated or recommended for treatment within the six (6) months immediately prior to Your Effective Date under this Policy. Pre-existing condition limitation does not apply after January 1, 2014.

PREFERRED ALLOWANCE means the amount a Preferred Provider will accept as payment in full for Covered Medical Expenses.

PREFERRED PROVIDER means a licensed or otherwise authorized medical professional who has entered into a signed agreement with the Company or the South Dakota Board of Regents to provide services to You. “In-Network Provider” also means aPreferred Provider.

PRESCRIPTION DRUGS means:
1) prescriptions legend drugs;
2) compound medications of which at least one ingredient is a prescription legend drug;
3) any other drugs which under the applicable state or federal law may be dispensed only upon written prescription of a Physician; and
4) injectable insulin.

PROOF OF LOSS means documents satisfactory to the Company that show a loss has occurred or that a claim for benefits is legitimate.

PROVIDER means any practitioner, group of practitioners, hospital or any other institution or entity that furnishes health care services and is licensed or otherwise authorized to render such services in the state where care is provided.

RIDER means a written document attached to this Policy that either supplements or amends the coverage from the Master Policy.

SCHEDULE OF BENEFITS means an outline of what We will pay for Covered Medical Expenses.

SICKNESS means Sickness or disease of You which causes loss, and originates while You are covered under this Policy.

TEETH mean the major portions of the existing individual teeth, regardless of fillings or caps; and are not carious, abscessed or defective.

TERMINATION DATE means the date on which benefits end.

USUAL AND CUSTOMARY means a reasonable charge which is:
1) Usual and Customary when compared with the charges made for similar services and supplies; and
2) Made to persons having similar medical conditions in the locality of the Policyholder.

No payment will be made under this Policy for any expenses incurred which in the judgment of the Company are in excess of Usual and Customary Charges.

**WE or Us** means Avera Health Plans, the company that underwrites this Policy.

**YOU or YOUR** means any person covered and eligible to receive benefits under this Policy.
HOW IS MY PRIVACY PROTECTED?

Your privacy is important and We strive to protect the confidentiality of your personal information. We do not sell or disclose any nonpublic personal financial information to any companies or to anyone else, except as required by law. You may obtain a copy of our privacy practices by calling toll-free at 1 (888) 322-2115 or visiting us online at www.averhealthplans.com.

AM I ELIGIBLE FOR THIS PLAN?

Domestic Students

Undergraduate:
All domestic undergraduate students taking five (5) or more credit hours per semester (three (3) hours in the summer) are eligible to enroll in this Plan.

Graduate:
All domestic graduate students and students seeking a doctorate degree regardless of credit hours are eligible to enroll in this Plan.

You are not eligible if you join any branch of the United States Armed Forces.

You are only eligible to enroll in this Plan during open enrollment periods or when you have a qualifying event.

International Students

All registered international students are required to purchase this Plan at the time of registration regardless of credit hours. International students, except for those entitled to establish a legal domicile in South Dakota, who has enrolled in any University, are required to purchase the Plan. Exemptions to this requirement may be granted by the South Dakota Board of Regents only when comparable or superior health insurance is provided for the student by the student’s sponsoring agency or group health plan. Students who transfer to a University in the spring and summer sessions may also be exempted by the University provided their previous institution required the purchase of comparable, non-refundable coverage and that coverage is still in force for the remainder of the academic year. There may be other eligible waivers per SDBOR policy 3:14.

NOTE:
Students must actively attend classes for at least the first 31 days after the date for which coverage is purchased. Internet classes that give credit hours and are sanctioned by the South Dakota Board of Regents will be considered active attendance. Home study, correspondence, Internet classes that do not give credit hours and television courses do not fulfill the eligibility requirements that
the student actively attend classes do not qualify. The Company maintains its right to investigate student status and attendance records to verify that eligibility requirements have been met. The Company’s only obligation is to refund premium if it is determined that a student who paid a premium was later found to not be eligible.

WHAT IF I AM NOT ELIGIBLE FOR THIS PLAN?
If you do not meet the eligibility requirements of this Plan, please contact the Avera Health Plans Service Center at toll-free 1 (888) 322-2115 for information on other coverage options. You may also access information by visiting www.AveraHealthPlans.com; click on Avera MyPlan.

WHAT ARE MY COVERAGE OPTIONS?
You have two coverage options:
Annual Coverage (12 months)
Session Coverage (Fall and/or Spring/Summer)

The Coverage Effective Date and Coverage Termination Dates are listed below:

<table>
<thead>
<tr>
<th>Coverage Purchase Option</th>
<th>Coverage Effective Date</th>
<th>Coverage Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual</td>
<td>08-01-2013</td>
<td>07-31-2014</td>
</tr>
<tr>
<td>Session:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>08-01-2013</td>
<td>12-31-2013</td>
</tr>
<tr>
<td>Spring/Summer</td>
<td>01-01-2014</td>
<td>07-31-2014</td>
</tr>
<tr>
<td>Summer</td>
<td>05-01-2014</td>
<td>07-31-2014</td>
</tr>
</tbody>
</table>

The summer coverage option is only available to students who have not been enrolled in previous spring semester and have registered for summer courses.

WHEN CAN I PURCHASE COVERAGE RIDERS?
You can purchase a coverage rider when you initially enroll in MyHealth Plan.

WHEN DO I PAY THE PREMIUMS?
Your premium due dates depend on how you chose coverage; either by session or for the year.
Eligibility requirements must be met each time a premium payment is due to continue insurance coverage. Premiums must be paid in order to be eligible for coverage.

**HOW DO I PAY MY PREMIUMS?**

Your premium will be charged to you. The amount due will be listed on your student billing statement. As part of the enrollment process, you must indicate whether or not you use tobacco. Your premium will be based on your response to the tobacco use question as well as your age and the coverage you have elected. You can view and pay your premium on the SDePay link available in WebAdvisor.

<table>
<thead>
<tr>
<th>Academic Institution</th>
<th>Website</th>
</tr>
</thead>
<tbody>
<tr>
<td>Black Hills State University</td>
<td><a href="http://www.bhsu.edu">www.bhsu.edu</a></td>
</tr>
<tr>
<td>Dakota State University</td>
<td><a href="http://www.dsu.edu">www.dsu.edu</a></td>
</tr>
<tr>
<td>Northern State University</td>
<td><a href="http://www.northern.edu">www.northern.edu</a></td>
</tr>
<tr>
<td>South Dakota School of Mines &amp; Technology</td>
<td><a href="http://www.sdsmt.edu">www.sdsmt.edu</a></td>
</tr>
<tr>
<td>South Dakota State University</td>
<td><a href="http://www.sdstate.edu">www.sdstate.edu</a></td>
</tr>
<tr>
<td>The University of South Dakota</td>
<td><a href="http://www.usd.edu">www.usd.edu</a></td>
</tr>
<tr>
<td>University Centers</td>
<td><a href="http://www.sduniversitycenter.org">www.sduniversitycenter.org</a></td>
</tr>
</tbody>
</table>

**Can I get a refund on my premium?**

You can receive a refund of your premium if you join the United States Armed Forces. To request your refund, you must send us documentation of joining the United States Armed Forces or your active duty documentation. You need to submit this documentation within three (3) months of joining the United States Armed Forces or your active duty.

**Can I terminate coverage?**

You may terminate coverage for you by notifying us in writing. Your notification has to be received prior to the date of termination. Your policy will be terminated at the end of the month following receipt of the written notification. You will be responsible for any premiums through the date of termination.

Termination will be the last day of the month in which we receive a signed consent. If termination results in a refund of premium it will be sent the following month.
ARE MY DEPENDENTS ELIGIBLE FOR COVERAGE AND WHEN CAN I ENROLL?

Your dependents are not eligible for coverage under this Plan.

You may enroll during open enrollment periods and you may also be enrolled under these conditions:
  • Appointment as a legal guardian of a Dependent
  • Birth or adoption of a child
  • Marriage
  • Forcible loss of coverage

These conditions only apply to you. Your dependents are not eligible for coverage under this Plan.

NOTE:

You must notify the Company within 30 days of the date of the specific event listed above in order for you to be eligible for coverage. Based on the notification and premium requirements being met, coverage will be effective on the date of the event. Notification must be made by contacting the Avera Health Plans Service Center at toll free (888) 322-2115.

Please refer to http://myhealth.sdbor.edu for the premium schedule or contact the Company at (605) 322-4545 or toll-free at 1 (888) 322-2115. The payment to the Company will only be available when a qualifying event occurs.

CAN I RENEW THE PLAN?

No, this Plan can not be renewed. It is effective only for this Plan Year.

WHAT IF I AM HOSPITALIZED WHEN THE PLAN TERMINATES?

The coverage provided under the Plan ends on the Termination Date. However, if you are hospitalized on the Termination Date from a covered Injury or Sickness for which benefits were paid before the Termination Date, Covered Medical Expenses for such Injury or Sickness will continue to be paid as long as you are hospitalized, for up to 90 days. This is called an "Extension of Benefits" provision. If this provision is exercised, you will be responsible for premium payment for each month in which benefits are paid on your behalf. If this provision has been used up, no additional benefits are available and no more payments will be made.
The total payments made on your behalf, both before and after the Termination Date, will not exceed the Maximum Benefit (Your Maximum Benefit amount is found in the Schedule of Benefits).

**HOW DO I GET CARE AT A HOSPITAL?**

If you need non-emergent hospital services, you must notify Avera Health Plans (AHP) Utilization Management before being admitted. If emergency hospital services are needed, you should go to the nearest hospital and you can notify AHP as soon as reasonably possible after the admission. Someone other than you may contact AHP on your behalf. The phone number for AHP is on the back side of your insurance identification card.

<table>
<thead>
<tr>
<th>Type of Admission</th>
<th>Notice Requirements</th>
<th>Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Emergency Admission</td>
<td>Five (5) working days before your planned Hospital Admission or as soon as reasonably possible.</td>
<td>Phone number: Toll-free: 888-605-1331</td>
</tr>
<tr>
<td>Emergency Admission</td>
<td>Two (2) working days after your Hospital Admission.</td>
<td>Phone number: Toll-free: 888-605-1331</td>
</tr>
</tbody>
</table>

**PLEASE NOTE:**
Notifying AHP of your hospital admission does not guarantee that We will pay for the services received. We will only pay for Medically Necessary services according to eligibility, the Schedule of Benefits, Exclusions, Limitations and maximums as stated in this Policy. A Medically Necessary service may be authorized by us but is not eligible for payment because the service is not a Covered Service, or other Exclusions, or Limitations apply.

**WHAT HEALTH CARE SERVICES REQUIRE A PRIOR AUTHORIZATION?**

- Inpatient hospital services
- Inpatient alcohol/chemical dependency treatment services
- Physical, occupation and speech therapy services after 30 visits per Plan Year
- CT scan/MRI
- Durable medical equipment

**DO I NEED TO GO TO THE STUDENT HEALTH CENTER BEFORE GETTING CARE ANYWHERE ELSE?**

No, you do not need to seek a referral from the Student Health Center. However, if you need specialty care, you should seek a referral from the Student Health Center.
Center or your primary care physician first. You will maximize your benefits by seeking care from the SHC

WHAT PROVIDERS CAN I SEE?

A list of Preferred Providers may be found by contacting the Company toll-free at 1 (888) 322-2115 or by visiting online at www.averahealthplans.com.

The availability of specific Preferred Providers is subject to change without notice. You should always confirm before receiving care that a provider is in-network by visiting the website listed above and/or by asking the provider when making an appointment for services.

Regardless of the provider, you are responsible for the payment of your Deductible. The Deductible must be paid before benefits are paid. The Company will pay according to the benefit limits in the Schedule of Benefits.

You will be responsible for all out-of-pocket expenses in excess of the insurance Policy benefits as described in the Schedule of Benefits and the Policy Limitations and Exclusions.

SCHEDULE OF BENEFITS

(Excluding Athletic Activity Injuries—see section on Athletic Activity Rider)

Plan Highlights:

- $500,000 Maximum Benefit (per Plan Year).
- $200 Deductible (per Insured Person, per Plan Year).
- Covered Medical Expenses provided by the Student Health Center (SHC) are covered at 100 percent of the Preferred Allowance and the Deductible does not apply.
- Care received from Preferred Providers is covered at a higher benefit level than care received from Out-of-Network Providers.
  - Care from Out-of-Network Providers will be covered at the Preferred Provider level if:
    - Care is for a Medical Emergency
- Claims are paid as follows:
  - Out-of-Network Providers—Paid at 60 percent of the Usual and Customary Charges for that service.
  - In-Network Providers—paid at the Preferred Allowance for that service.
Benefits will be paid up to the Maximum Benefits for each service as scheduled below. You will be responsible for all out-of-pocket expenses in excess of the Policy benefits as described in the Schedule of Benefits and the Policy Limitations and Exclusions.

Covered Medical Expenses include:

<table>
<thead>
<tr>
<th>INPATIENT</th>
<th>PREFERRED PROVIDER</th>
<th>OUT-OF-NETWORK PROVIDER</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Hospital</strong> - Prior authorization is required.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Intensive Care</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Maternity Care</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Routine Newborn Care</strong> - while Hospital Confined; and routine nursery care provided immediately after birth.</td>
<td>80% of Preferred Allowance Up to 48 hours for vaginal delivery or 96 hours for cesarean section delivery</td>
<td>60% of Usual &amp; Customary Charges Up to 48 hours for vaginal delivery or 96 hours for cesarean section delivery</td>
</tr>
<tr>
<td><strong>Therapy Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Physical</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>• Occupational</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Speech</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgeon's Fees</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Anesthetist</strong> - professional services in connection with inpatient surgery.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Physician's Visits</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Pre-admission Testing</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Service Type</td>
<td>Preferred Allowance</td>
<td>Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>---------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>Mental Health Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Biologically Based Mental Illness</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Alcohol/Chemical Dependency Treatment Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Physician's Visits</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Chiropractic Office Visits</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Surgeon's Fees</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Day Surgery Miscellaneous</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Anesthetist</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Preventive Health Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Therapy Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Medical Emergency Expenses</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Diagnostic X-ray &amp; Laboratory Services</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Service</td>
<td>Preferred Allowance</td>
<td>Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>---------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Radiation Therapy &amp; Chemotherapy</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Tests &amp; Procedures - Diagnostic services and medical procedures performed by a Physician, other than Physician’s Visits, Therapy, X-rays and lab procedures.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Injections - When administered in the Physician’s office and charged on the Physician’s statement.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Mental Health Services – Including treatment for ADHD. See Benefits for Biologically Based Mental Illness.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Biologically Based Mental Illness - See Benefits for Biologically Based Mental Illness.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>CT SCAN/MRI – Prior authorization required.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>OTHER</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Durable Medical Equipment (DME) Prior authorization is required on the following items:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Negative Pressure Wound Pump. C-PAP, Bi-PAP, V-PAP, CPROM</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>• Wheelchairs</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• DME items (rental or purchase) over $5,000</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Consultant Physician Fees - When requested and approved by the attending Physician.</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Dental Treatment - Made necessary by Injury, accident or cancer to Sound Teeth. Exception: Benefits will be paid up to $50 per tooth for the extraction of impacted wisdom teeth.</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Alcohol/Chemical Dependency Treatment Services</td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>
WHAT ARE THE PHARMACY BENEFITS?

When you use the network pharmacy, you will be able to get up to a 30-day supply of medications. Benefits for prescription drugs are payable only when the prescriptions are dispensed by a network pharmacy. The benefits per prescription are below:

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>$10 Co-pay</td>
</tr>
<tr>
<td>Tier 2</td>
<td>$25 Co-pay</td>
</tr>
<tr>
<td>Tier 3</td>
<td>40% Coinsurance</td>
</tr>
</tbody>
</table>

Please present your identification card to the network pharmacy when the prescription is filled. If you do not use a network pharmacy, you will be responsible for paying the full cost for the prescription.

If you do not present your identification card to the network pharmacy, you will need to pay for the prescription and then submit a manual claim form along with a paid receipt in order to be reimbursed. To obtain a manual claim form or more information regarding mail-order prescriptions or to locate a network pharmacy, please visit us online at http://myhealth.sdbor.edu or call the Company toll-free at 1 (888) 322-2115.

WHAT IF I HAVE OTHER INSURANCE?

When you are covered by more than one health plan, state law permits the health plans to follow a process called coordination of benefits. When you have a claim, coordination of benefits will determine how much each health plan should pay. The plan that pays first is the primary plan and the plan that pays second is the secondary plan. The goal is to make sure that the combined payments of all plans don’t add up to more than your covered health care expenses.

If your Injury or Sickness is due to an act or omission of another, benefits payable by this Policy are subject to recovery from amounts eventually paid to you by or on behalf of the other person.

HOW DOES COORDINATION OF BENEFITS WORK?

You will be asked to identify all the plans that cover members of your family. We need this information to determine whether we are the primary or secondary plan.

- When you have a claim, the primary plan always pays first, as if the secondary plan did not exist. The secondary plan may consider the benefits paid by the primary plan to determine payment.
• Any plan that does not contain your state’s coordination of benefits rules will always be primary.

Make sure all of your providers, including pharmacies for prescription drugs, know that you are covered by more than one plan. Some providers may send claims to your secondary plan, but some do not. In this case, you must send us the provider’s claim and the explanation of benefits from the other plan so we can calculate the correct payment.

DO WE COORDINATE BENEFITS WITH ALL PLANS?
No, we don’t coordinate benefits with all plans. We coordinate benefits with plans that are:

• Group or individual insurance contracts and subscriber contracts,
• Group or group-type insurance contracts that are self-insured by the employer,
• Group-type contracts,
• Medical care components of long-term care contracts such as skilled nursing care,
• Medical coverage in automobile no-fault and traditional automobile fault-type contracts, and
• Medicare and other government benefits, as permitted by law, except for medical assistance. That part of the definition of plan may be limited to the hospital, medical and surgical benefits of the governmental program.

We don’t coordinate benefits with plans that are:

• Hospital indemnity coverage benefits or other fixed indemnity coverage,
• Accident-only coverage,
• Specified disease or specified accident coverage,
• Limited benefit health coverage,
• School accident-type coverage that covers students for accidents only, including athletic injuries, either on a 24-hour basis or on a to-and-from-school basis,
• Medicare supplement policies,
• A state plan under the medical assistance program,
• A governmental plan, which by law, provides benefits that are in excess of those of any private insurance plan or other nongovernmental plan, or
• Benefits provided in long-term care insurance policies for non-medical services including personal care, adult day care, homemaker services, assistance with activities of daily living, respite care and custodial care, or for contracts that pay a fixed daily benefit without regard to expenses incurred or the receipt of services.
Each contract for coverage, whether or not it is a plan that we coordinate with, is a separate plan. If a plan has two parts and coordination of benefit rules apply only to one of the two, each of the parts is treated as a separate plan.

WHICH PLAN PAYS FIRST?

When we coordinate benefits with other plans, the following rules determine which plan pays first. This is only an outline of the most common coordination of benefits situations. If your situation is not described below, please call our Service Center to assist you in determining who pays first.

WHAT IF I AM COVERED UNDER MORE THAN ONE INSURANCE PLAN?

1. A plan that does not contain a coordination of benefits provision always pays first.
   (There is one exception: coverage that is obtained through membership in a group that supplements part of a basic package of benefits may provide that the supplementary coverage will be in addition to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are in addition to base-plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed-panel plan to provide out-of-network benefits.)

2. If you are a subscriber on one plan and a dependent on another plan, the plan that covers you as a subscriber is primary.

3. If you are covered as a subscriber on two plans, the following rules apply:
   - **Active or Inactive Insured Person.** The plan that has covered you as an active Insured Person pays before a plan that covers you as an inactive person or dependent.
   - **COBRA.** The plan covering you as an Insured Person will pay before COBRA or a state continuation plan.
   - **Medicare.** If you have Medicare coverage, please see the section, How Does Medicare Coordination of Benefits Work?
   - **Longer or Shorter Length of Coverage.** The plan that has covered you as a subscriber the longest pays first.
If the rules above don’t determine who pays first, then each plan covers half of the allowed expenses. We will not pay more than we would have paid if we were the primary plan. You must give us any facts we need to apply these coordination of benefit rules and determine the correct payment.

**HOW DOES MEDICARE COORDINATION OF BENEFITS WORK?**

The table below explains how Medicare coordination of benefits works when you are an employee, retiree or COBRA participant and qualify for Medicare because of age, disability or end-stage renal disease.

<table>
<thead>
<tr>
<th>How You Qualified for Medicare</th>
<th>Your Status</th>
<th>Employer Group Size</th>
<th>The Plan That Pays First</th>
</tr>
</thead>
<tbody>
<tr>
<td>65+ years of age</td>
<td>Named Insured Person</td>
<td>Less than 20 participants</td>
<td>Medicare</td>
</tr>
<tr>
<td>65+ years of age</td>
<td>Named Insured Person</td>
<td>20+ participants</td>
<td>MyHealth</td>
</tr>
<tr>
<td>Disabled</td>
<td>Named Insured Person</td>
<td>Less than 100 participants</td>
<td>Medicare</td>
</tr>
<tr>
<td>Disabled</td>
<td>Named Insured Person</td>
<td>100+ participants</td>
<td>MyHealth</td>
</tr>
<tr>
<td>End-stage renal disease – less than 30 months</td>
<td>Named Insured Person</td>
<td>Any size</td>
<td>MyHealth</td>
</tr>
<tr>
<td>End-stage renal disease – more than 30 months</td>
<td>Named Insured Person</td>
<td>Any size</td>
<td>Medicare</td>
</tr>
</tbody>
</table>

**DO I NEED TO AUTHORIZE THE RELEASE OF INFORMATION?**

No. Your authorization is not needed for us to obtain or release the necessary information. Each person claiming benefits under this plan must give us any facts we need to apply these coordination of benefits rules and to determine the correct benefits payable. We may get the facts we need from or release necessary facts to other organizations or persons for the purpose of applying these rules.

**WHAT HAPPENS IF THE OTHER PLAN PAYS WHEN WE ARE RESPONSIBLE?**

If another plan pays for a service that we should have paid for, we will pay the provider or, if required by law, pay the other plan. The amount paid will be treated
as though it was a benefit under our plan. We do not need to pay that amount to the provider of service.

**WHAT HAPPENS IF THERE IS AN OVERPAYMENT?**

If we pay more than we are responsible for, we may recover the overpayment from the person or organization that we paid in accordance with the laws of the State of South Dakota.

**WHAT OTHER SERVICES ARE COVERED?**

The following services are Covered Medical Expenses. Please remember that:

- These services may have additional Limitations, so please read the Schedule of Benefits carefully.
- You are responsible for the Deductible, Co-payment, or Coinsurance included in your Plan.
- These services will be paid the same as any other Sickness.

**Maternity Testing**

The following maternity routine test and screening exams will be considered, if all other Policy provisions have been met. This includes a pregnancy test, CBC, Hepatitis B Surface Antigen, Rubella Screen, Syphilis Screen, Chlamydia, HIV, Gonorrhea, Toxoplasmosis, Blood Typing, ABO, RH Blood Antibody Screen, Urinalysis, Urine Bacterial Culture, Microbial Nucleic Acid Probe, AFP Blood Screening; Pap Smear, and Glucose Challenge Test (at 24-28 weeks gestation). One ultrasound will be considered in every pregnancy, without additional diagnosis. Any subsequent ultrasounds can considered if a claim is submitted with the pregnancy record and ultrasound report that establishes Medically Necessary. Additionally, the following test will be considered for women over thirty-five (35) years of age: Amniocentesis/AFP Screening; and Chromosome Testing. Fetal Stress/Non-Stress tests are payable. For additional information regarding Maternity Testing, please contact the Company at toll-free at 1 (888) 322-2115.

**Mammography**

You can receive a mammography based on the chart below:

<table>
<thead>
<tr>
<th>Age</th>
<th>Mammography Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>35-39</td>
<td>1 baseline mammogram</td>
</tr>
</tbody>
</table>
You can receive a mammography more often if your doctor recommends it.

**Breast Reconstruction**

If your physician recommends, after a covered mastectomy, you can receive a breast reconstruction for:

1) Reconstruction of the breast on which the mastectomy has been performed;
2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3) Prostheses and physical complication of all states of mastectomy, including lymphedemas.

**Drug Treatment of Cancer or Life-Threatening Conditions**

When prescription drug benefits are payable under the Policy, benefits will be provided for drugs for treatment of cancer or life-threatening conditions although the drug has not been approved by the Food and Drug Administration for that indication if that drug is recognized for treatment of such indication in one of the standard reference compendia or in the appropriate medical literature. The prescribing Provider must submit documentation supporting the proposed off-label use or uses to the Company if requested. Coverage shall include Medically Necessary services associated with the administration of such drugs.

Benefits shall be subject to all Deductible, Co-payment, Coinsurance, Limitations or any other provisions of the Policy.

**Diabetes**

Benefits will be paid the same as any other Sickness for equipment, supplies, and self-management training and education, including medical nutrition therapy, for treatment of Insured Person’s diagnosed with diabetes if prescribed by a Physician. Medical nutrition therapy does not include any food items or nonprescription drugs.

The benefit for Medically Necessary equipment and supplies shall include blood glucose monitors, blood glucose monitors for the legally blind, test strips for glucose monitors, urine testing strips, insulin, injection aids, lancets, lancets devices, syringes, insulin pumps and all supplies for the pump, insulin infusion devices, prescribed oral agents for controlling blood sugars, glucose agents, glucagon kits, insulin measurement and administration aids for the visually impaired, and other medical devices for the treatment of diabetes.
Diabetes self-management training and education shall be covered if: (a) the service is provided by a Provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified as a diabetes educator; and (b) the training and education is based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association or the South Dakota Department of Health.

The benefit for diabetes self-management training is limited to (a) Insured Persons who are newly diagnosed with diabetes or have received no prior diabetes education; (b) Insured Persons who require a change in current therapy; (c) Insured Persons who have a co-morbid condition such as heart disease or renal failure, or (d) Insured Persons whose diabetes condition is unstable. Under these circumstances, no more than two comprehensive education programs per lifetime and up to eight follow-up visits per year are covered. Coverage is limited to the closest available qualified education program that provides the necessary management training to accomplish the prescribed treatment.

Benefits shall be subject to Deductible, Co-payment, Coinsurance, Limitations or any other provisions of the Policy.

**Biologically-Based Mental Illness**

Benefits will be paid the same as any other Sickness for services and supplies for the Medically Necessary treatment of biologically-based mental illness when recommended by a Provider.

Biologically-based mental illness means schizophrenia and other psychotic disorders, bipolar disorder, major depression and obsessive-compulsive disorder.

Benefits shall be subject to Deductible, Co-payment, Coinsurance, Limitations or any other provisions of the Policy.

**Dental Anesthesia**

Benefits shall be provided for dental anesthesia and related hospital Covered Medical Expenses for services and supplies provided to an Insured Person who:

1) Is a child under age five (5); or

2) Is severely disabled or otherwise suffers from a developmental disability as determined by a Provider which places such child at serious risk.

Benefits shall be subject to Deductible, Co-payment, Coinsurance, Limitations or any other provisions of the Policy.
**Prostate Cancer Screening**

Benefits will be paid the same as any other Sickness for prostate cancer screening. Subject to the following:

1) An annual medically recognized diagnostic examination, including a digital rectal examination and a prostate-specific antigen test, as follows:
   a.) For asymptomatic men aged fifty (50) and over; and
   b.) For men aged forty-five (45) and over at high risk for prostate cancer; and
   c.) 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.

Benefits shall be subject to Deductible, Co-payment, Coinsurance, Limitations or any other provisions of the Policy.

**WHAT SERVICES ARE NOT COVERED?**

No benefits will be paid for: a.) loss or expense caused by, contributed to, or resulting from; or b.) treatment, services or supplies for, at, or related to:

1) Acne; acupuncture; allergy, including allergy testing;
2) Addiction, such as: nicotine addiction and caffeine addiction; non-chemical addiction, such as: gambling, sexual, spending, shopping, working and religious; codependency;
3) Assistant Surgeon Fees;
4) Learning disabilities;
5) Biofeedback;
6) Circumcision;
7) Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this Policy; removal of warts, non-malignant moles and lesions;
8) Dental treatment, except as specifically provided in the Schedule of Benefits;
9) Surgery or Treatment that does not meet medical necessity;
10) Elective abortion;
11) Eye examination, eyeglasses, contact lenses, prescriptions or fitting of eyeglasses or contact lenses, vision correction surgery, or other treatment for visual defects and problems; except when due to a disease process;
12) Foot care including: care of corns, bunions (except capsular or bone surgery), calluses;
13) Hearing examinations or hearing aids; or other treatment for hearing defects and problems. “Hearing defects” means any physical defect of the ear which does or can impair normal hearing, apart from the disease process;
14) Hirsutism; alopecia;
15) Injury or Sickness for which benefits are paid under any Workers’ Compensation or Occupational Disease Law or Act, or similar legislation;
16) Injury sustained while a.) In any interscholastic, club or professional sport, contest or competition; b.) Traveling to or from such sport, contest or competition as a participant; or c.) while participating in any practice or conditioning program for such sport, contest or competition;
17) Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;
18) Prescription Drugs, services or supplies as follows:
   a.) Therapeutic devices or appliances, including: hypodermic needles, syringes, support garments and other non-medical substances, regardless of intended use (except as specifically provided in the Benefits for Diabetes);
   b.) Birth control and/or contraceptives, oral or other, whether medication or device, regardless of intended use, except as mandated by the federal government;
   c.) Immunization agents, biological sera, administered on an outpatient basis;
   d.) Drugs labeled, “Caution-limited by federal law to investigational use” or experimental drugs; except as specifically provided in the Policy;
   e.) Products used for unapproved cosmetic indications;
   f.) Drugs used to treat or cure baldness; anabolic steroids used for body building;
   g.) Anorectics-drugs used for the purpose of weight control;
   h.) Fertility agents or sexual enhancement drugs such as Parlodel, Pergonal, Clomid, Profasi, Metrodin, Serophene or Viagra;
   i.) Growth hormones; or
   j.) Refills in excess of the number specified or dispensed after one (1) year of date of the prescription;
19) Reproductive/Infertility services including but not limited to: family planning; fertility tests; infertility (male or female), including any services or supplies rendered for the purpose or with the intent of inducing conception; premarital examinations; impotence, organic or otherwise; tubal ligation; vasectomy; sexual reassignment surgery; reversal of sterilization procedures;
20) Services provided normally without charge by the University's Health Service; or services covered or provided by the student health fee;
21) Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomandibular joint dysfunction; nasal and sinus surgery;
22) Skydiving, parachuting, hang gliding, glider flying, parasailing, sail planning, bungee jumping, or flight in any kind of aircraft, except while riding as a passenger on a regularly scheduled flight of a commercial airline;
23) Sleep disorders;
24) Supplies, except as specifically provided in the Policy;
25) Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the Policy;
26) Treatment in a government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
27) War or any act of war, declared or undeclared; or while in the armed forces of any country (a pro-rata premium will be refunded upon request for such period not covered); and
28) Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.

WHAT IF I PURCHASE THE ATHLETIC ACTIVITY RIDER?

All student athletes who are members of intercollegiate athletic teams sponsored by the South Dakota Board of Regents are eligible for benefits under the athletic rider if:

1) Selection was made on the MyHealth online application; and
2) Additional premium has been paid.

Benefits will be paid for an Injury sustained by an Insured Person while:

1) Actually engaged, as an official representative of the South Dakota Board of Regents, in the play or practice of an intercollegiate sport under the direct supervision of a regularly employed coach or trainer of the South Dakota Board of Regents; or
2) Actually being transported as a member of a group under the direct supervision of a duly delegated representative of the South Dakota Board of Regents for the purpose of participating in the play or practice of a scheduled intercollegiate sport.

**Schedule of Benefits for the Athletic Activity Rider:**

<table>
<thead>
<tr>
<th>Maximum Benefit</th>
<th>$3,000 (for each Injury)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductible</td>
<td>$100 (per Plan Year)</td>
</tr>
<tr>
<td>Preferred Provider Coinurance</td>
<td>80%</td>
</tr>
<tr>
<td>Out-of-Network Coinurance</td>
<td>70%</td>
</tr>
</tbody>
</table>

Benefits are payable under this Rider for Covered Medical Expenses less the above-stated Deductible incurred due to an Injury related to athletic activity. The total payable for all Covered Medical Expenses will never be more than the Maximum Benefit of $3,000 for any one Injury.

No benefits will be paid for loss or expenses caused by, contributed to or resulting from:
1) Infections, except pyogenic infections caused wholly by a covered injury;
2) Cysts, blisters or boils;
3) Overexertion; heat exhaustion; fainting;
4) Hernia, regardless of how caused; or
5) Artificial aids such as crutches, braces, appliances and artificial limbs.

This Rider takes effect and expires concurrently with the Policy to which it is attached, and is subject to all of the terms and conditions of the Policy not inconsistent therewith.

GLOBAL EMERGENCY ASSISTANCE SERVICES

If you are a student insured with this insurance Policy, you and your insured spouse and minor child(ren) are eligible for International SOS. The requirements to receive these services are as follows:

International Students, insured spouse and insured minor child(ren): You are eligible to receive International SOS worldwide, except in your home country.

Domestic Students, insured spouse and insured minor child(ren): You are eligible for International SOS when 100 miles or more away from your campus address and 100 miles or more away from your permanent home address or while participating in a Study Abroad program.

International SOS includes Emergency Medical Evacuation and Return of Mortal Remains that meet the United States State Department requirements. The Emergency Medical Evacuation services are not meant to be used in lieu of or replace local emergency services such as an ambulance requested through emergency 911 telephone assistance. All International SOS services must be arranged and provided by International SOS, any services not arranged by International SOS will not be considered for payment. Key Services include:

♦ 24-hour access to SOS Physicians who provide emergency and routine medical advice
♦ Medical and dental referrals
♦ Medical Evacuation/Repatriation
♦ Repatriation of Mortal Remains
♦ Outpatient Case Management
♦ Arrange for inpatient admission and identify receiving physician
♦ Arrange ground transportation and accommodation for accompanying family members
♦ Assistance with documentation for insurance claim forms
♦ Access to Travel Health Information
Online Country Guides
Online Travel Health Reports
Access to International SOS Clinics
Online security reports to over 200 countries
International SOS Crisis Center
Consultations with Security professionals
Legal Referrals
Emergency Message Transmissions
Lost Document Advice and Assistance
Translation and Interpreters
Regular E-mail Updates
Member cards and guides

International SOS 24-Hour Alarm Centers

If calling from the US, Mexico, Central or South America:
Philadelphia, PA
24 hours: +1-215-942-8478 (call collect where available)
Within U.S.A. call: +1-800-523-6586

If calling from Europe, CIS, Africa or the Middle East:
London, England
24 hours: +44-20-8762-8008 (call collect where available)

If calling from Asia,
Singapore
24 hours: +65-6338-7800 (call collect where available)

If calling from Australia or the Pacific Rim:
Sydney, Australia
24 hours: +61-2-9372-2468 (call collect where available)

Additional Alarm Center and Clinic contact information can be found at the International SOS website at www.internationalsos.com/world-network.

When calling the International SOS Alarm Center, please be prepared to provide:

1) Caller’s name, telephone and (if possible) fax number, and relationship to the patient
2) Patient’s name, age, sex and Reference Number
3) Description of the patient's condition
4) Name, location and telephone number of hospital, if applicable
5) Name and telephone number of the attending physician
6) Information of where the physician can be immediately reached
International SOS is not travel or medical insurance but a service provider for emergency medical assistance services. All medical costs incurred should be submitted to your health plan and are subject to the policy limits of your health coverage. All assistance services must be arranged and provided by International SOS. Claims for reimbursement of services not provided by International SOS will not be accepted. Please refer to your International SOS brochure for Program Guidelines as well as Limitations and Exclusions pertaining to the International SOS program.

F1 Visa holders, as part of your program, the United States Government has required you by law to have adequate evacuation ($10,000) and repatriation ($7,500) coverage in the event of a medical emergency. The plan provides benefits up to these limits. Should you require these services, they are arranged through the Emergency Assistance Program from International SOS.

WHAT IF I HAVE A COMPLAINT?

The state of South Dakota requires us to provide you with the following complaint procedures. We encourage you to contact our Service Center with any concerns you may have. If you are not satisfied with a decision of ours that affects your coverage, you may submit a written complaint to us.

Once your complaint is filed, there are two levels of review:
1. First-level review (also referred to as standard internal review)
2. Second-level review (also referred to as an external review)

When Can I Submit a Complaint?
You or the person you authorize in writing to represent you (your authorized representative) may request a first-level review by submitting a written complaint or by completing a complaint form. You must submit the complaint within 180 days after the date you were notified of the action that is causing the complaint. (For example, if the date of service was January 1 but you didn’t receive notice that the claim was denied until March 1, you would have 180 days from March 1 to submit your complaint.)

How Do I Submit A Complaint?
Complaint forms are available from our Service Center or on our website at www.AveraHealthPlans.com. You may send the complaint form or written request to:

Attn: Complaint and Appeals Coordinator
What If I Have a Complaint That Is Urgent?

If you have an urgent complaint, you can request to have your review expedited. This type of review may be needed when:

- A delay could jeopardize your life, health or ability to regain maximum function or
- A provider who knows your condition tells us that a delay would cause severe pain that could not be adequately managed without the care or treatment you are requesting.

The time frame for us to respond to an urgent complaint is 72 hours. Your provider must call Medical Management at 1 (888) 605-1331 to request an expedited complaint review. The phone number is also listed on the back of your member ID card. You do not need to submit your urgent complaint in writing. We will notify you and your provider by phone or fax of our decision. You will also receive written notification of our decision. The notification will be the same as the notifications for other complaints. If the urgent complaint is concurrent, meaning you are receiving services at this time, you will not be responsible for charges related to the complaint from the time you submit the complaint until a decision has been made.

What Happens After I Submit the Complaint?

When we receive your complaint, we will send you or your authorized representative a letter within three working days to let you know we received your request. We will also tell you about the review process and how to contact our complaint and appeals coordinator. You have the right to submit documents, written comments, records or other information related to the complaint for consideration during the review. If requested, you will be provided, free of charge, copies of all relevant documentation that is not confidential or privileged used to make the initial decision.

Who Reviews the First-level Complaint?

Your first-level complaint review will be handled by someone not previously involved with the initial decision. The review will take into account all relevant documents and information submitted, even if the information was reviewed in the initial decision. If necessary, your complaint will be reviewed by a physician of the appropriate specialty who understands the complaint process, whose scope of practice includes the services or treatment being reviewed and who was not involved in the initial decision.
How Will I Be Notified of the Decision?
We will notify you or your authorized representative of the decision in writing. The decision will include:

- The titles and qualifying credentials of the person or persons participating in the process,
- A statement summarizing your complaint,
- The reviewer’s decision and the reason for the decision,
- The evidence or documentation source used to make the decision,
- Your right to request a second-level review (also known as an external review) if you are not satisfied with the decision. We will include information on the second-level external review complaint review process which is handled by the Division of Insurance,
- Your right to contact the Division of Insurance. The letter includes the address and toll-free telephone number and
- A reference to the specific plan provision on which the decision was made,
- A description of any additional material or information necessary to complete the request and an explanation as to why the information is necessary,
- If the decision was made relying on an internal rule or guideline, a copy of the internal rule or guideline will be provided to you free of charge,
- An explanation of the scientific or clinical judgment for making the decision, applying the terms of the health plan to your medical circumstances, if the decision was based on medical necessity or investigational and experimental grounds and
- A statement indicating your right to bring a civil action in a court of competent jurisdiction.

What If I Am Not Satisfied With First-Level Complaint Review Decision?
If you are not satisfied with the first-level complaint review decision, you have the right to request a second-level external review through the Division of Insurance.

An external review means an organization not connected with us reviews your complaint and makes a decision.
You or your authorized representative may request an external review by contacting us or the South Dakota Division of Insurance. If the South Dakota Division of Insurance approves your request, they will assign an Independent Review Organization.

**How Do I File A Second-Level External Review Complaint?**

In order to be eligible, you must file the complaint within four months (120 days) of the final decision. The cost is $25 and will be refunded to you if the Independent Review Organization’s decision is in your favor or if your request is not eligible for external review.

A second-level external review process can take up to 45 days for processing. When filing your request for a second-level external review, you will need to send in the following to the address listed below:

- A completed External Review Request form. This form can be found at [www.AveraHealthPlans.com](http://www.AveraHealthPlans.com).
- A $25 application fee payable to S.D. Division of Insurance (check or money order).
- Photocopy of insurance identification card.
- A copy of the letter from us stating our decision is final and all internal review procedures have been exhausted or that we waived the requirements to exhaust all internal review procedures.
- A copy of your certificate of coverage or insurance policy benefit booklet, which lists the benefits under your health benefit plan.

South Dakota Division of Insurance  
Attn: External Review  
445 E. Capitol Ave.  
Pierre, SD 57501

**How Will I Be Notified of the Second-Level External Review Decision?**

The Independent Review Organization will notify you or your authorized representative, us and the Division of Insurance of the decision. The written notification will include:

- The qualifying credentials of the person or persons participating in the process,
- A statement summarizing your complaint,
- The date the independent review organization received the assignment from the director to conduct the external review,
• The date the external review was conducted, the date and reviewers’ decision along with the reason for the decision,
• The evidence or documentation source used to make the decision,
• A reference to the specific plan provision on which the decision was made,
• A description of any additional material or information necessary to complete the request and an explanation as to why the information is necessary,
• If the decision was made relying on an internal rule or guideline, a copy of the internal rule or guideline will be provided to you, free of charge,
• An explanation of the scientific or clinical judgment for making the decision, applying the terms of the health plan to your medical circumstances, if the decision was based on medical necessity or investigational and experimental grounds and
• A statement indicating your right to bring a civil action in a court of competent jurisdiction.

What If I Want To Know More About the External Review Process?

If you want to know more, please call our Service Center for additional information about the external review process. You may also contact the South Dakota Division of Insurance for assistance.

DOES THE PROVIDER BILL THE INSURANCE?

Preferred Provider – Reimbursement of Charges
Yes, when you receive Covered Services from a Preferred Provider, we pay the Preferred Provider directly, and you will not have to submit claims for payment. Receiving Covered Services from a Preferred Provider insures that you receive In-Network benefits. You will be required to pay applicable Deductible, Co-payment or Coinsurance to the Preferred Provider for services in accordance with the Schedule of Benefits and this Policy.

Out-of-Network Provider – Reimbursement of Charges
Yes, you may need to notify us when receiving Covered Services from an Out-of-Network Provider. This puts you at risk of paying higher out-of-pocket prices for your Covered Services in accordance with your Out-of-Network benefits. When you receive medical care from an Out-of-Network Provider, we will generally make a payment to that Provider if the Out-of-Network Provider submits a claim to the Company. When the Out-of-Network Provider will not file a claim with us, you will be responsible for notifying us of the charges incurred as outlined in the process below. You are ultimately responsible for payment to an Out-of-Network Provider.
Notification Process
You must give the Company written notice of the costs to be reimbursed within 120 days of receiving the service. The notice must be sent to the Company and must include:

1) Name of the Insured Person for whom services were incurred;
2) Insured Person’s ID number;
3) Receipt of the cost(s) incurred;
4) Name of Provider
5) Provider’s Tax Identification Number

Information can be mailed or faxed to:

Avera Health Plans
Attn: Claims Dept.
3816 S. Elmwood Avenue
Sioux Falls, SD 57105
Fax: (605) 322-4540

WHAT SERVICES ARE ONLINE?
Please visit our website at http://myhealth.sdbor.edu to apply or to view and print brochures, coverage receipts, claim status and other information regarding MyHealth Plan.

Keep this Policy document as a general summary of this coverage. The Master Policy on file with the South Dakota Board of Regents contains all of the provisions, Limitations, Exclusions and qualifications of your benefits, some of which may not be included in this document. The Master Policy is the contract and will govern and control payment of benefits.