My Health Plan
A
STUDENT HEALTH INSURANCE
LIMITED 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
University of South Dakota
University Center

Academic Year: 2008-2009
Plan Year: August 15, 2008-August 31, 2009
Policy No: BOR1

Please Note:
• Covered Services - This is a Limited Benefit Plan. 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, Suite 100
  Sioux Falls, SD 57105-6538
  Phone: 1 (888) 322-2115
  Fax: (605) 322-4540
  www.AveraHealthPlans.com or
  http://myhealth.sdbor.edu
PRIVACY NOTICE

The Company's Privacy Commitment

THE COMPANY 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 THE COMPANY OR TO ANYONE ELSE, EXCEPT AS REQUIRED BY LAW.

The Type of Information We Collect

The Company 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 Person 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.

The Company 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 promulgated and published thereunder and with respect thereto as 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 the Company.

The Company 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. The Company 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 the Company’s website at www.AveraHealthPlans.com.

If you have any questions about this Privacy Notice, call the Company at (605) 322-4500 or contact us at Avera Health Plans 3816 S Elmwood Avenue, Suite 100, Sioux Falls, SD 57105.
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DEFINITIONS
Definitions are provided to help you understand terms used in this Policy.

BASIC COVERAGE means the Student Health Insurance Limited 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 Schedule of Benefits;
4) not in excess of Usual and Customary Charges;
5) in excess of the amount stated as a Deductible, if any, and;
6) 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 or per occurrence (for each Injury or Sickness) as specified in the Schedule of Benefits.

DEPENDENT means the spouse and unmarried children under nineteen (19) years of age, or twenty-nine (29) years if they are a full-time Dependent student at an accredited institution of higher learning, who are not self-supporting.

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 do not meet the health care need for a Sickness or Injury and 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.

All injuries sustained in one accident, including all related conditions and recurrent symptoms of these injuries will be considered one Injury. Injury does not include loss which results wholly or in part, directly or indirectly, from disease or other bodily infirmity. Covered Medical Expenses incurred as a result of an injury that occurred prior to this Policy’s Effective Date will be considered a Sickness under this Policy.

INVESTIGATIONAL means medical services or technologies that have not yet met the Company’s evidence based standards for safety and effectiveness listed below. Proof of safety and effectiveness is determined through a process of evaluation of the medical evidence. New technologies are evaluated solely on the scientific evidence, whereas
existing technology effectiveness is determined first by the evidence, then by professional standards and then by expert opinion. The criteria used to evaluate technologies include:

1) The technology must have received final approval from the appropriate regulatory bodies.
2) The scientific evidence must be conclusive regarding its effects on health outcomes.
3) The overall health outcomes associated with a technology must be positive after considering both health improvements and negative side effects.
4) The technology must be at least as effective as existing alternatives.
5) Health outcome improvements obtained in the Investigational setting must be reproducible in the community setting.

Services that are covered under the Policy, and are not Investigational, 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.

LIMITED BENEFIT PLAN means that the coverage for Injury or Sickness is restricted. The Limitations are outlined in the Schedule of Benefits.

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.
2) Be used to diagnose or treat Your condition caused by disease, Injury or congenital malformation.

3) Be consistent with current standards of good medical practice for Your medical condition in the medical community in the area where services are rendered.

4) Be provided in the most appropriate site and at the most appropriate level of service for Your medical condition.

5) 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.

6) 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.

7) 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.

**NETWORK AREA** means the 50 mile radius around the local school campus You are attending.

**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), 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 when performed by a MD.

**PHYSIOTHERAPY** 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 Limited Benefit Plan for the State of South Dakota University System. The term “Policy” also means Plan.


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.

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 a Preferred Provider.

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. All related conditions and recurrent symptoms of the same or a similar condition will be considered one Sickness. Covered Medical Expenses incurred as a result of an Injury that occurred prior to this Policy’s Effective Date will be considered a Sickness under this Policy.

TEETH mean the major portions of the existing individual teeth, regardless of fillings or caps; and is 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 nonpublic personal information. We do not sell or disclose any nonpublic personal financial information to any companies or to any one 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 http://myhealth.sdbor.edu.

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 taking three (3) credit hours per semester and students seeking a doctorate degree are eligible to enroll in this Plan.

Eligible domestic students who do enroll may also insure their Dependents. Dependent eligibility expires at the same time of the Insured Person. You are not eligible if you join any branch of the United States Armed Forces.

International Students

All registered international students taking credit hours and their Dependents are required to purchase this Plan at the time of registration. International students, except for those entitled to establish a legal domicile in South Dakota, who has enrolled in any University, their spouses and their Dependents 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, spouse and Dependents by the student’s sponsoring agency or government. 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.

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 Company at 1 (888) 322-2115 for information on other coverage options. You may also access information by visiting www.AveraHealthPlans.com; click on Avera MyPlan.

WHEN DOES THE PLAN BEGIN AND END?

You have two coverage options:
1) Annual Coverage and Payment Option
2) Session Coverage and Payment Option

The premium due dates, coverage effective and coverage termination dates are listed below:

<table>
<thead>
<tr>
<th>Coverage Purchase Option</th>
<th>Premium Due Date</th>
<th>Coverage Effective Date</th>
<th>Coverage Termination Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Annual</td>
<td>09-04-08</td>
<td>08-15-08</td>
<td>08-31-09</td>
</tr>
<tr>
<td>Session:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fall</td>
<td>09-04-08</td>
<td>08-15-08</td>
<td>01-13-09</td>
</tr>
<tr>
<td>Spring</td>
<td>01-16-09</td>
<td>01-14-09</td>
<td>05-08-09</td>
</tr>
<tr>
<td>Summer</td>
<td>05-13-09</td>
<td>05-09-09</td>
<td>08-31-09</td>
</tr>
</tbody>
</table>

WHEN CAN I PURCHASE COVERAGE RIDERS?

You can purchase a coverage rider when you initially enroll in My Health Plan.

WHEN DO I PAY THE PREMIUMS?

Your premium due dates depend on how you chose coverage; either by session or for the year. Please see the grid above for the premium due dates.

Eligibility requirements must be met each time a premium payment is due to continue insurance coverage. Premiums must be paid on the due date 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 on your academic institution’s website. You can locate SDePay in your WebAdvisor portal, typically located under Current Student Link.

<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>University of South Dakota</td>
<td><a href="http://www.usd.edu">www.usd.edu</a></td>
</tr>
<tr>
<td>University Center</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. You need to submit this documentation within three (3) months of joining the United States Armed Forces.

WHEN CAN I ENROLL A DEPENDENT?

You can enroll a Dependent when you enroll for your coverage. Please note that your Dependents can not be enrolled:

- prior to your effective date, or
- later than your termination date.

Dependents may also be enrolled at times other than at your enrollment under these conditions:

- Appointment as a legal guardian of a Dependent
- Birth or adoption of a child
- Marriage, which permits adding the new spouse and the new spouse’s children
- Dependent resumes full-time student status

NOTE:

You must notify the Company within 30 days of the date of the specific event listed above in order for your Dependent to be eligible for coverage. Based on the notification...
and premium requirements being met, Dependent coverage will be effective on the date of the event. Notification must be made by completing the My Health Online Application at http://myhealth.sdbor.edu and sending the appropriate premium amount to:

Avera Health Plans, Inc.
Attention: Enrollment Department
3816 S Elmwood Avenue, Suite 100
Sioux Falls, SD 57105

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.

Dependents may no longer be eligible for coverage under these conditions:
- Active Duty in the United States Armed Forces
- Completion of the Dependent’s full-time schooling
- Death
- Dependent child who is not a full-time student or permanently disabled reaches age 19
- Divorce, annulment or legal separation of a spouse
- Marriage of a Dependent child
- Obtain Medicare eligibility

**CAN I RENEW THE PLAN?**

No, this Plan can not be renewed. It is effective only for this academic 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 to go to the hospital, you must notify Healthcare Medical Technology, Inc. (HCMTI) before you are admitted. If it is an emergency, go to the nearest hospital, you can notify HCMTI after your admission. You can also have someone else call HCMTI for you. You can find the phone number for HCMTI 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>PREFERRED:</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.preauthonline.com">www.preauthonline.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone number:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Toll-free: 1 (877) 400-0114 or Local: (605) 977-0169</td>
</tr>
<tr>
<td>Emergency Admission</td>
<td>Two (2) working days after your Hospital Admission.</td>
<td>PREFERRED:</td>
</tr>
<tr>
<td></td>
<td></td>
<td><a href="http://www.preauthonline.com">www.preauthonline.com</a></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phone number:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Toll-free: 1 (877) 400-4114 or Local: (605) 977-0169</td>
</tr>
</tbody>
</table>

PLEASE NOTE:
Notifying HCMTI of your hospital admission does not guarantee that the services will be paid. 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.

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

Yes, you must use the resources of the Student Health Center first where treatment will be administered, or referral issued. Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained are excluded from coverage. A referral issued by the Student Health Center must accompany the claim when submitted.

A Student Health Center (SHC) referral for outside care is not necessary under the following conditions:
   1) Medical Emergency. The student must return to SHC for necessary follow-up care;
2) Medical care received when the student is more than 50 miles from campus;
3) Maternity care;
4) Psychotherapy care;
5) The individual seeking care is a Dependent of the Insured Person,
6) When service is rendered at another facility during break or vacation periods;
7) When the SHC is closed; or
8) Medical care obtained when a student is no longer able to use the SHC due to a change in student status.

Exceptions:
- Your Dependents are not required to use the Student Health Center.
- If you are not in school or the student health center is closed, then go to a physician or hospital for treatment.

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 http://myhealth.sdbor.edu.

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:
- $50,000 Maximum Benefit for each Sickness or Injury (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.
• Except as described above, a SHC referral is necessary for coverage.
• Care received from Preferred Providers is covered at a higher benefit level than care received from Out-of-Network Providers.
  o 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:
  o Out-of-Network Providers—Paid at 80 percent of the Usual and Customary Charges for that service.
  o 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>Hospital Expense</strong> - daily semi-private room rate; and general nursing care provided by the hospital; Hospital Miscellaneous Expenses such as the cost of the operating room, laboratory tests, X-ray examinations, anesthesia, drugs (excluding take home drugs) or medicines, therapeutic services, and supplies. Number of days payable under this benefit will include admission date but not the discharge date.</td>
<td>80% of Preferred Allowance $1,500 max. per day</td>
<td>60% of Usual &amp; Customary Charges $1,500 max. per day</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>Paid as any other Sickness/ 80% of Preferred Allowance Up to 48 hours for vaginal delivery or 96 hours for cesarean section delivery</td>
<td>Paid as any other Sickness/ 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>Physiotherapy</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Surgeon’s Fees</strong> - if two or more</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>procedures are preformed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 25% of all subsequent procedures.</strong></td>
<td>Allowance</td>
<td>Charges</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td><strong>Anesthetist - professional services in connection with inpatient surgery.</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Physician’s Visits - benefits are limited to one visit per day and do not apply when related to surgery.</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Pre-admission Testing - payable within 3 working days prior to admission.</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Physician’s Visits - benefits are limited to one visit per day.</strong></td>
<td>Paid as any other Sickness/ 80% of Preferred Allowance/ $5,000 maximum per plan year</td>
<td>Paid as any other Sickness/ 60% of Usual &amp; Customary Charges/ $5,000 maximum per plan year</td>
</tr>
<tr>
<td><strong>Psychotrahy - benefits are limited to one visit per day.</strong></td>
<td>Paid as any other Sickness/ 80% of Preferred Allowance</td>
<td>Paid as any other Sickness/ 60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Biologically Based Mental Illness</strong></td>
<td>Paid as any other Sickness/ 80% of Preferred Allowance</td>
<td>Paid as any other Sickness/ 60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>OUTPATIENT</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgeon’s Fees - if two or more procedures are performed through the same incision or in immediate succession at the same operative session, the maximum amount paid will not exceed 50% of the second procedure and 25% of all subsequent procedures.</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Day Surgery Miscellaneous - related to scheduled surgery performed in a Hospital, including the cost of the operating room; laboratory test and X-ray examinations, including professional fees; anesthesia; drugs or medicines; and supplies. Usual and Customary Charges for Day Surgery Miscellaneous are based on the Outpatient Surgical Facility Index.</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Anesthetist - professional services administered in connection with outpatient surgery.</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Physician’s Visits - benefits are limited to one visit per day. Benefits do not apply when related to Surgery or Physiotherapy.</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td><strong>Physiotherapy - benefits are limited to one visit per day. Outpatient Physiotherapy benefits are payable only for a condition that required surgery or Hospital Admission: 1.) within 30 days immediately preceding such Physiotherapy; or 2.) within the 30 days immediately following the attending Physician’s release for rehabilitation. (Without Surgery or Hospital Admission</strong></td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Service</td>
<td>Prefered Allowance Coverage</td>
<td>Usual &amp; Customary Charges Coverage</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-----------------------------</td>
<td>------------------------------------</td>
</tr>
<tr>
<td>Medical Emergency Expenses - use of the emergency room and supplies. Treatment must be rendered within 72 hours from time of injury or first onset of Sickness. (The $100 copay/Deductible per visit is in addition to the Policy Deductible and will be waived if admitted).</td>
<td>80% of Usual &amp; Customary Charges/ $100 copay per visit</td>
<td>80% of Usual &amp; Customary Charges/ $100 copay per visit</td>
</tr>
<tr>
<td>Diagnostic X-ray &amp; Laboratory Services</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Radiation Therapy &amp; Chemotherapy</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Tests &amp; Procedures - diagnostic services and medical procedures performed by a Physician, other than Physician's Visits, Physiotherapy, X-rays and lab procedures.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Injections - when administered in the Physician's office and charged on the Physician's statement.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Psychotherapy - including all related or ancillary charges incurred as a result of a Mental or Nervous Disorder (including Prescription drugs). Benefits are limited to one visit per day. See Benefits for Biologically Based Mental Illness.</td>
<td>50% of Preferred Allowance/ $1,000 maximum per plan year</td>
<td>50% of Usual &amp; Customary Charges/ $1,000 maximum per plan year</td>
</tr>
<tr>
<td>Biologically Based Mental Illness - see Benefits for Biologically Based Mental Illness.</td>
<td>Paid as any other Sickness/80% of Preferred Allowance</td>
<td>Paid as any other Sickness/60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Cat Scan/MRI</td>
<td>80% of Preferred Allowance/ $500 maximum per occurrence</td>
<td>60% of Usual &amp; Customary Charges/ $500 maximum per occurrence</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>80% of Usual &amp; Customary Charges</td>
<td>80% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Durable Medical Equipment - a written prescription must accompany the claim when submitted. Replacement equipment is not covered.</td>
<td>80% of Preferred Allowance/ $250 maximum per plan year</td>
<td>60% of Usual &amp; Customary Charges/ $250 maximum per plan year</td>
</tr>
<tr>
<td>Consultant Physician Fees - when requested and approved by the attending Physician.</td>
<td>80% of Preferred Allowance</td>
<td>60% of Usual &amp; Customary Charges</td>
</tr>
<tr>
<td>Dental Treatment - made necessary by Injury to Sound Teeth. Exception: Benefits will be paid up to $50 per tooth for the extraction of impacted wisdom teeth.</td>
<td>80% of Usual &amp; Customary Charges</td>
<td>80% of Usual &amp; Customary Charges</td>
</tr>
</tbody>
</table>
Alcoholism - inpatient treatment only, not to exceed 30 days in any six-month period. Maximum Lifetime Benefit will not exceed 90 days per Insured Person. Paid as any other Sickness/Preferred Allowance/Paid as any other Sickness/Preferred Allowance/Paid as any other Sickness/Preferred Allowance

Drug Abuse
	Paid under Psychotherapy
	Paid as any other Sickness/Preferred Allowance/Paid as any other Sickness/Preferred Allowance

WHAT ARE THE PHARMACY BENEFITS?

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

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Your Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug</td>
<td>$10 Co-pay</td>
</tr>
<tr>
<td>Brand/Formulary Drug</td>
<td>$25 Co-pay</td>
</tr>
<tr>
<td>Brand/Non-Formulary Drug</td>
<td>40% Coinsurance</td>
</tr>
</tbody>
</table>

There is a benefit maximum on prescription drugs of $1,000 per Plan Year for all drug tiers or types combined. 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?

Even if you have other insurance, the Policy may cover unpaid balances, Deductibles and pay those eligible medical expenses not covered by other insurance.

All benefits will be in excess of all other valid and collectible insurance and other benefit programs and will apply only when such benefits are exhausted. 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.

However, benefits of this section will not be applied to the first $100 of medical expenses incurred.
Covered Medical Expenses exclude amounts not covered by the primary carrier due to penalties imposed on you for failing to comply with Policy provisions or requirements.

**IMPORTANT:**
This does not apply to you if you do not have other medical insurance or if your other insurance does not cover the loss.

**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. Pre-natal vitamins are not covered. 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>
<tr>
<td>40-49</td>
<td>1 mammogram <em>every other</em> year</td>
</tr>
<tr>
<td>50 and older</td>
<td>1 mammogram <em>every</em> year</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) Congenital conditions except as specifically provided for Newborn or adopted Infants;
8) Cosmetic procedures, except cosmetic surgery required to correct an Injury for which benefits are otherwise payable under this Policy or for newborn or adopted children; removal of warts, non-malignant moles and lesions;
9) Dental treatment, except as specifically provided in the Schedule of Benefits;
10) Elective Surgery or Elective Treatment;
11) Elective abortion;
12) Expenses incurred for medical treatment rendered outside of the Student Health Center for which no prior approval or referral is obtained.
13) 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;
14) Foot care including: care of corns, bunions (except capsular or bone surgery), calluses;
15) 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;
16) Hirsutism; alopecia;
17) Immunizations; preventive medicines or vaccines, except where required for treatment of a covered Injury;
18) Injury or Sickness for which benefits are paid under any Workers’ Compensation or Occupational Disease Law or Act, or similar legislation;
19) 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;

20) Organ transplants, including organ donation;

21) Participation in a riot or civil disorder; commission of or attempt to commit a felony; or fighting;

22) Pre-existing Conditions for a period of six (6) months, except for individuals who have been continuously insured under other University-sponsored insurance for at least six (6) consecutive months. Credit will be given for the time the Insured Person was covered under previous Creditable Coverage if the Creditable Coverage was continuous to a date not more than sixty-three (63) days prior to the Insured Person’s Effective Date under this Policy;

23) 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;
   c.) Immunization agents, biological sera, blood or blood products 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;

24) 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;

25) Routine Newborn Infant Care, well-baby nursery and related Provider charges in excess of 48 hours for vaginal delivery or 96 hours for cesarean delivery;

26) Routine physical examinations and routine testing; preventive testing or treatment; screening exams or testing in the absence of Injury or Sickness, except as specifically provided in the Policy;

27) Services provided normally without charge by the University’s Health Service; or services covered or provided by the student health fee;

28) Skeletal irregularities of one or both jaws, including orthognathia and mandibular retrognathia; temporomanibular joint dysfunction; nasal and sinus surgery;
29) 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;
30) Sleep disorders;
31) Supplies, except as specifically provided in the Policy;
32) Surgical breast reduction, breast augmentation, breast implants or breast prosthetic devices, or gynecomastia; except as specifically provided in the Policy;
33) Treatment in a government hospital, unless there is a legal obligation for the Insured Person to pay for such treatment;
34) 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
35) Weight management, weight reduction, nutrition programs, treatment for obesity, surgery for removal of excess skin or fat, and treatment of eating disorders such as bulimia and anorexia. Exception: benefits will be provided for the treatment of dehydration and electrolyte imbalance associated with eating disorders.
36) Routine, preventive or screening examinations for testing unless Medically Necessary is established based on medical records.

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 My Health 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>Benefit</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maximum Benefit</td>
<td>$3,000 (for each Injury)</td>
</tr>
<tr>
<td>Deductible</td>
<td>$100 (per Plan Year)</td>
</tr>
<tr>
<td>Preferred Provider Coinsurance</td>
<td>80%</td>
</tr>
<tr>
<td>Out-of-Network Coinsurance</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 Assistance (SOS). The requirements to receive these services are as follows:

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

Domestic Students, insured spouse and insured minor child(ren): You are eligible for 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.

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 SOS services must be arranged and provided by SOS, any services not arranged by 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
♦ Repatriation of Mortal Remains  
♦ 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  
♦ Quarterly Newsletters and Regular Fax/E-mail Updates  
♦ Member cards and guides

**SOS 24-Hour Alarm Centers**

If calling from the US, Mexico, Central or South America:

**Philadelphia, PA**

24 hours: 1-215-942-8226 (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, Australia or the Pacific Rim:

**Singapore**

24 hours: 65-6338-7800 (call collect where available)

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

When calling the SOS Operations 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
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 SOS. Claims for reimbursement of services not provided by SOS will not be accepted. Please refer to your SOS brochure for Program Guidelines as well as Limitations and Exclusions pertaining to the 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?
You are encouraged to resolve your individual problems by contacting:

Avera Health Plans Service Center
3816 S Elmwood Avenue, Suite 100
Sioux Falls, SD 57105
(605) 322-4545
Toll-free: 1 (888) 322-2115

The Service Center Associate will work with you to resolve your problem. If the Service Center Associate is not able to assist you with your issue or you are not satisfied with the outcome, you may wish to have the issue reviewed further. Please contact the Company or visit us online at http://myhealth.sdbor.edu for more information regarding Complaint Resolution.

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

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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 and/or Dependent for whom services were incurred;
2) Insured Person’s and/or Dependent’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, Suite 100  
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, enrollment cards, coverage receipts, claim status and other information regarding *My Health* Plan.

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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.