

**SOUTH DAKOTA RISK POOL PLAN
PLAN DOCUMENT**

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\$1,000, \$3,000, and \$10,000 Deductible Plans

Plan Year

Begins July 1 and ends June 30 of the following year. Annual deductible and out-of-pocket limit accumulators and premium changes are effective each July 1.

Annual Deductible

Plan A - \$1,000
Plan B - \$3,000
 \$3,000 with HSA Qualifying Plan Option
Plan C - \$10,000

Note: Once an enrollee has selected one of the four plan options available, the enrollee may not change plans except at the beginning of a new fiscal year and they may not decrease the deductible amount. The Risk Pool administrator will notify you of the deadline for making plan design changes for the new plan year.

Coinsurance

Plan A, Plan B, and Plan C - The plan pays 75% of eligible medical expenses after the deductible is met. The plan pays 75% of pharmaceutical expenses, which are not subject to the deductible. If the enrollee does not comply with disease management program(s) as determined by the plan's Medical Director, payment for medical and pharmaceutical expenses will be reduced to 50%.

Plan B with HSA Qualifying Plan Option - The plan pays 75% of eligible medical and pharmaceutical expenses after the deductible is met. No benefits are paid prior to meeting the deductible. If the enrollee does not comply with disease management program(s) as determined by the plan's Medical Director, payment for medical and pharmaceutical expenses will be reduced to 50%.

Enrollee's Responsibility – Payment of the deductible and coinsurance amounts to the providers is the enrollee's responsibility. Failure to pay these amounts to the provider can result in loss of eligibility for the Risk Pool.

Enrollee Annual Out-of-Pocket Maximum

Plan A - \$3,250 (Deductible and 25% Coinsurance for first \$9,000) for eligible medical services. This out-of-pocket maximum does not include the separate \$1,500 annual out-of-pocket maximum for pharmacy benefits. No out-of-pocket limits if enrollee does not comply with disease management program(s).

Plan B - \$5,250 (Deductible and 25% Coinsurance for first \$9,000) for eligible medical services. This out-of-pocket maximum does not include the separate \$1,500 annual out-of-pocket maximum for pharmacy benefits. No out-of-pocket limits if enrollee does not comply with disease management program(s).

Plan B with HSA Qualifying Plan Option - \$5,100 (Deductible and 25% Coinsurance for first \$8400) for eligible medical and pharmacy services. This plan does not pay any pharmacy or medical benefits until the deductible has been met. No out-of-pocket limits if enrollee does not comply with disease management programs(s).

Plan C - \$12,250 (Deductible and 25% Coinsurance for first \$9,000) for eligible medical services. This out-of-pocket maximum does not include the separate \$1,500 annual maximum for pharmacy benefits. No out-of-pocket limits if enrollee does not comply with disease management program(s).

Pharmacy

Plan A, Plan B, and Plan C - Enrollees pay a coinsurance amount of 25% for each eligible prescription to a maximum of \$1,500 per year. This out-of-pocket maximum is in addition to the out-of-pocket maximum for other covered medical services. The deductible requirement only applies to medical expenses, not to pharmacy benefits. Unless there is a verifiable medical reason, the coinsurance amount increases to 50% of each eligible prescription if enrollee does not comply with a disease management or prescription intervention program. There is no out-of-pocket maximum if enrollee does not comply with the pharmacy intervention or disease management program. All prescriptions shall be filled with generic products if available, unless an exception has been granted due to a verifiable medical reason. To request an exception, the enrollee or provider may contact the Health Care Management Company. If an exception has not been granted and a prescription is filled with non-generic products, the coinsurance amount increases to 50% and the enrollee will also be responsible for the difference in cost between the generic and non-generic product. These additional costs will not apply towards the out-of-pocket maximum.

Plan B with HSA Qualifying Option - Enrollees pay for all pharmacy costs until the deductible has been met by the combination of both covered medical and pharmacy benefits. After the deductible has been met, enrollees pay a coinsurance amount of 25% for each eligible prescription until the \$5100 out-of-pocket maximum (medical and pharmacy combined) has been met. Unless there is a verifiable medical reason, the coinsurance amount increases to 50% of each eligible prescription if enrollee does not comply with a disease management or prescription intervention program. There is no out-of-pocket maximum

if enrollee does not comply with the pharmacy intervention or disease management program. All prescriptions shall be filled with generic products if available, unless an exception has been granted due to a verifiable medical reason. To request an exception, the enrollee or provider may contact the Health Care Management Company. If an exception has not been granted and a prescription is filled with non-generic products, the coinsurance amount increases to 50% and the enrollee will also be responsible for the difference in cost between the generic and non-generic product. These additional costs will not apply towards the out-of-pocket maximum.

Plan Year Maximums

30 days inpatient treatment for alcoholism and substance abuse in any six month period.

\$2,000 for outpatient treatment for alcoholism and substance abuse.

\$900 for up to 30 outpatient visits for mental health conditions other than those biologically based.

\$8,000 for Durable Medical Equipment.

\$2,500 for treatment of Temporomandibular Joint Syndrome (TMJ).

Lifetime Maximums

\$2,000,000 per enrollee.

90 days inpatient treatment for alcoholism and substance abuse.

\$25,000 for procurement for single or multiple transplant organs.

\$8,000 for transportation and lodging costs related to an organ transplant (per transplant occurrence).

Pre-existing Condition Waiting Period

- (1) Children enrolled under age 19 who have been without health care coverage for six months or longer will have a six month pre-existing condition waiting period for medical services.
- (2) Children under age 19 enrolled during the open enrollment period who have been without health care coverage for 12 months or longer will not have pre-existing condition waiting period.

Termination of Benefits

All coverage and benefits provided by the Risk Pool will terminate when any of the following apply:

- (1) The enrollee fails to pay premiums in accordance with the set terms.
- (2) The enrollee no longer meets all eligibility requirements.
- (3) The enrollee has knowingly made any false or fraudulent statement of a material fact with reference to any application for the risk pool or statement relating to eligibility for the risk pool. The enrollee knowingly presents or causes to be presented a false or fraudulent claim or who submits any proof in support of such a claim for the payment of a loss upon the risk pool or who prepares, makes, or subscribes a false or fraudulent account, certificate, affidavit or proof of loss, or other document or writing, with the intent of presenting or suing in support of such a claim. If for any reason we make payment under this policy in error, we may recover the amount we paid.

Unless specifically listed, coverage or exclusions are subject to interpretation of the Risk Pool and the enrollee's recourse is limited to the appeal and legal action provisions of this plan.

Covered Daily Hospital Room and Board and Medical Services

The medically necessary daily charge made by the hospital for the most common semi-private accommodations when medically necessary and pre-authorized by the plan's Health Care Management Company.

Covered Miscellaneous Hospital Services

Medically necessary charges for:

- (1) Use of an ambulance to the closest treatment facility.
- (2) Charges for services of a physician or related provider as outlined in SDCL 58-17-54.
- (3) Blood and blood plasma, and the administration of it.
- (4) Other medically necessary services and supplies provided for the patient's use during the stay, if charged for by the hospital, extended care facility, or acute rehabilitation facility.
- (5) Diagnostic and therapeutic services of a hospital.
- (6) Durable medical equipment when pre-authorized.

Covered Surgical Services

Covered surgical charges for surgery performed in a hospital or in a doctor's office, clinic, or ambulatory surgical facility includes:

- (1) Fees for surgical procedures performed by a physician.
- (2) Fees for an assistant surgeon (M.D., Physician's assistant or the equivalent), if medically necessary and pre-authorized before surgery is performed.
- (3) Fees for anesthesia.

Covered Anesthesia Services

Anesthetics, oxygen, and their administration by a qualified professional.

Covered Preventive Services

Preventive services are not subject to deductible and coinsurance requirements when services are provided in South Dakota by South Dakota providers. Coverage will include: office visit, cost of procedure, ancillary charges, biopsies fees, laboratory fees, pathology fees, physician services, reading/interpretive fees, and testing fees.

(1) The Plan covers the following immunizations as a preventive service:

Vaccine ▼	Age ▶	Birth	1 month	2 month	4 month	6 months	12 months	15 months	18 months	19-23 months	2-3 years	4-6 years
Hepatitis B		HepB	HepB			HepB						
Rotavirus				Rota	Rota	Rota						
DTaP				DTAP	DTAP	DTAP		DTAP				DTAP
HIB				Hib	Hib	Hib	Hib					
Pneumococcal				PVC	PVC	PVC	PVC					*
Inactivated Poliovirus				IPV	IPV	IPV						IPV
Influenza						Yearly (*certain risk groups after age 5)						
MMR							MMR					MMR
Varicella							Varicella					Varicella
Hepatitis A							HepA 2 doses				*	
Meningococcal											*	

Vaccine ▼	Age ▶	7-10 years	11-12 years	13-18 years	19-49 years	50-64 years	65 and >
DTaP			TDaP	** TDaP	***1 dose Td booster every 10 years		
Human Papillomavirus			HPV (3 doses)	**HPV Series	***HPV, 3		
Meningococcal		* MCV4	MCV4	** MCV4	* 1 or more doses		
Pneumococcal		* PPV			* 1-2 doses		***1 dose
Influenza		* Influenza yearly			*	***One dose yearly	

Hepatitis A	* HepA Series	* 2 doses
Hepatitis B	** HepB Series	* 3 doses
Inactivated Poliovirus	**IPV Series	
MMR	**MMR Series	***1 or 2 doses * 1 dose
Varicella	**Varicella Series	***2 doses
Zoster		***1 dose

Recommended for all groups.

* Certain high risk groups or other risk factor present.

**Catch up immunizations.

***For those who lack evidence of immunity.

Schedule is based on CDC recommendations as of 5/2009

- (2) The Plan covers one cancer screening colonoscopy every 10 years as a preventive service beginning at age 50.
- (3) The Plan covers charges for screening by low-dose or digital mammography as a preventive service for cancer screening or diagnostic purposes for females 35 years of age or older as follows:
 - (a) a baseline mammogram for women 35 to 39 years of age;
 - (b) a mammogram each plan year for women 40 years of age or older
- (4) The Plan covers charges for an annual examination for diagnostic prostate cancer screening as a preventive service as follows:
 - (a) an annual examination for asymptomatic men aged fifty and over or for men aged forty-five and over at a high risk for prostate cancer; and
 - (b) medically indicated diagnostic testing at intervals recommended by a physician for males of any age who have a prior history of prostate cancer.
- (5) The Plan covers charges for a routine pap smear, thin prep screening, and the associated office visit every plan year as a preventive service.
- (6) The Plan covers charges for well child care visits as a preventive service as follows:
 - (a) Birth to 12 months, 5 exams: 1 between birth and 2 months, 1 exam at 2, 4, 6, and 9 months,
 - (b) 1 to 2 years, 2 exams
 - (c) 2 to 19 years, 1 exam each Plan year

Covered Out-of-Hospital Care and Other Covered Charges

- (1) Medically necessary charges by physicians or related providers as outlined in SDCL 58-17-54.
- (2) Blood and blood plasma, and its administration.
- (3) Chemotherapy.
- (4) Optometric services for the diagnosis or treatment of a medical condition or disease (e.g. glaucoma) or for an injury to the eye. Coverage also includes the cost of eyeglasses or contact lenses required because of an eye injury or cataract surgery.
- (5) Hearing testing for covered children (newborns up to 1 year old) and if necessary, hearing aids and their fitting up to age 8.
- (6) Non-dental services needed because of injury to teeth unless injury to the teeth or their surrounding tissue or structure is caused by chewing; for surgical removal of impacted or partially impacted teeth; for removal of tumors or cysts; or for drainage of an abscess or cyst.
- (7) Non-dental services and supplies provided for a jaw condition if needed because of an injury, medically necessary surgery or treatment of TMJ (temporomandibular joint syndrome) up to the annual maximum and subject to pre-authorization.
- (8) Services and supplies provided in conjunction with sinus surgery if medically necessary and pre-authorized. A second opinion is required if repeat surgery is needed.
- (9) Insulin pumps and glucometers. (Diabetic test strips, lancets, and medically necessary related supplies are covered under the Prescription Drug Plan.)
- (10) Medically necessary outpatient speech (that is not already provided or covered by a school system) occupational, and physical therapy that is prescribed by a physician. Visits are limited to 10 visits per medical occurrence. To be an eligible expense, visits above the 10-visit limit must be pre-authorized *before* receiving services. The Plan does not cover additional visits for the same problem which are not pre-authorized and approved. (The patient is limited to 10 visits per medical occurrence even if the 10 visits extend over two plan years.)

- (11) Medically necessary private-duty nursing when part of a written home health care treatment plan and provided by a nurse affiliated with a certified home health care agency. (The plan does not cover nursing care if the nurse resides in the enrollee's home or is a member of the enrollee's immediate family.)
- (12) Subject to the annual maximum, initial rental or purchase, at the Plan's option, of medically necessary durable medical equipment, such as crutches, braces, wheelchairs, and other prostheses needed for the treatment of a disease, illness, or injury. Repairs or replacements of prostheses and other equipment must also be considered medically necessary for the patient's condition, and will be consistent with current equipment. The Plan will not cover equipment prescribed solely for convenience or because it is the most recent model. Personal comfort or convenience items, including items and supplies related to the use of durable medical equipment (e.g., batteries, battery rechargers, AD/DC adapter plugs, etc.) are *not* covered by the Plan.
- (13) Charges for covered services provided at the Human Services Center or performed by nurses of the South Dakota Department of Health acting within the scope of their license.
- (14) Services provided by the South Dakota Department of Health Family Planning Clinics including contraceptive implants and removal and Depo-Provera injections.
- (15) Radioactive isotope therapy.
- (16) Radiotherapy.
- (17) Charges for the following services and supplies qualify as covered home health care charges but only to the extent that the charges are pre-authorized as medically necessary and received during convalescence in the covered enrollee's home:
 - (a) Skilled nursing care provided or supervised by a registered nurse, affiliated with a certified home health care agency.
 - (b) Home health aide services (mainly patient care).
 - (c) Physician ordered physical, occupational, speech, and respiratory therapy.
 - (d) Medical social services by a licensed medical or psychiatric social worker who is supervised by a physician.
 - (e) Covered medical supplies and equipment.
 - (f) Hospice care provided in the home.

The following charges do not qualify as covered home health care charges:

- (a) Charges for services rendered by the enrollee, an enrollee of the family, or by any person who resides in the enrollee's home. The enrollee's family consists of the enrollee, the enrollee's spouse, children, brothers, sisters, and parents of either the enrollee or the enrollee's spouse.
- (b) Charges for custodial care.

- (18) The Plan covers charges for the following non-experimental organ transplant services approved by the Food and Drug Administration:
- (a) heart;
 - (b) lung;
 - (c) bone marrow and stem cell transplants for certain conditions;
 - (d) kidney;
 - (e) pancreas;
 - (f) liver; and,
 - (g) cornea.

Benefits are payable for recipients covered by the Plan except for a limit on organ procurements fees. Covered charges include, but are not limited to:

- (a) pre-transplant evaluation;
 - (b) organ procurement/listing fees, surgical, storage, and transportation costs incurred or directly related to the donation of the organ used in one of the organ transplant procedures described above. The maximum lifetime benefit for eligible procurement services will not exceed \$25,000 per person;
 - (c) inpatient expenses and medication;
 - (d) all professional fees;
 - (e) reasonable transportation costs (mileage reimbursement based on the IRS allowable reimbursement for medical-related travel) to and from the site of the organ transplant procedure. Expenses are covered for the organ transplant recipient and a companion for the procedure only;
 - (f) necessary and reasonable lodging for the organ transplant recipient and a companion incurred at the site of the covered organ transplant procedure during the transplant benefit period; and
 - (g) medically necessary follow-up care.
- (19) HPV (human papillomavirus) screening, when medically necessary to aid in a diagnosis after a borderline Pap smear;
- (20) In compliance with the Women's Health and Cancer Rights Act, if a enrollee receives benefits in connection with a mastectomy, the Plan covers the following services:
- (a) reconstruction of the breast on which the mastectomy was performed;
 - (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - (c) prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
- (21) Coverage for reconstructive services needed because of an accident or a child's (under the age of 18) birth defect.
- (22) Coverage for covered chiropractic treatments and services, subject to review for medically necessary and treatment effectiveness. A second opinion may be necessary.

- (23) Coverage for prenatal care, delivery, and postpartum examinations. Blood tests and pap smears performed during the prenatal exam or postpartum checkup are also considered covered charges.

In compliance with Newborns' and Mothers' Health Protection Act of 1996, the Plan provides the following maternity health benefits;

- (a) A minimum of 48 hours of inpatient care for a mother and her covered newborn following a vaginal delivery and a minimum of 96 hours of inpatient care following a delivery by cesarean section.
 - (b) However, if the treating physician determines through standardized medical criteria that the entire stay is not necessary, and the patient and the doctor agree that the enrollee can go home, the Plan is not required to pay for the entire 48 or 96 hour hospital stay.
 - (c) Regardless of the length of the hospital stay, the Plan will cover one follow-up home visit to verify the condition of both the enrollee and the newborn. One home visit will be covered even if the mother and/or child are hospitalized for the entire 48 or 96 hours.
- (24) Benefits are payable for inpatient and outpatient treatment for mental and nervous conditions and alcohol and substance abuse by a qualified, licensed provider when pre-authorized.
- (25) The prescription drug program covers most outpatient prescription drugs. Medically necessary, covered medications that are prescribed and administered during an approved confinement are payable under the Plan.
- (26) Diabetic and cardiac education. The Plan covers education sessions received within four months of the original diagnosis. An additional four to five education sessions will be covered if/when a diabetic moves from Type II diabetes (diet controlled) to Type I (insulin dependent).
- (27) Ossatron lithotripsy procedure (extracorporeal shock wave treatment for chronic Proximal Plantar Fasciitis) requires pre-authorization or a second opinion. The Plan covers facility and physician charges associated with this procedure if the procedure is pre-authorized and conservative treatments have been tried for six months and failed to resolve the problem. Conservative treatments include icing and anti-inflammatory prescriptions.

Description of Plan Limitations and Exclusions

The Plan does not pay any benefits for the following services or supplies:

- (1) Provided before the enrollee was covered by the Plan or after coverage ends;
- (2) Not medically necessary;
- (3) Provided without a physician's prescription, recommendation, or approval;
- (4) Services which are experimental in nature or drugs that are not approved by the Food and Drug Administration (FDA) or covered by the Plan;
- (5) Excess costs above the Plan's accepted maximums;
- (6) Provided in connection with custodial care;
- (7) Covered by or as a benefit under Medicare, Medicaid, or any other plan or insurance;
- (8) Which would not have been billed if benefits were not available;
- (9) For which the enrollee is not legally required to pay;
- (10) For which the Risk Pool cannot legally provide benefits;
- (11) Services for illness or injury sustained while working for pay or profit that are paid under a Workers Compensation plan or any other insurance coverage;
- (12) For an injury or illness caused by a war, by participation in a riot, or while committing a felony;

- (13) Provided by a family or member of enrollee's household. This exclusion does not apply if the family or household member is the only licensed health care provider in the local area and is acting within the normal scope of the licensed health care provider's employment.
- (14) General, routine health exams if over 19 years of age (including routine annual physicals or employment-related physicals);
- (15) Screenings for HIV or hepatitis;
- (16) Charges for food, food substitutes, food supplements including infant formulas, and vitamins which are purchased for consumption on an outpatient basis, whether prescribed or not (excluding formula for the treatment of phenylketonuria (PKU) and prescribed prenatal vitamins);
- (17) Over-the-counter drugs or supplies, or prescribed drugs/supplies which are available over the counter (other excluded drugs and pharmaceutical products are listed under (52));
- (18) Minoxidil in any of its forms;
- (19) Personal comfort or convenience items, including TVs and telephone usage while hospitalized, sauna and whirlpool devices, and items and supplies related to the use of durable medical equipment (e.g., batteries, battery recharges, AC/DC adapter plugs, blood pressure cuffs, etc.);
- (20) Exercise equipment and club membership;
- (21) Whirlpool or aqua massage or massage therapy
- (22) Reconstruction of an external part of the body for cosmetic reasons or to correct a developmental defect, unless services are needed because of an accident or a birth defect (for a child under age 18);
- (23) Enhancements designed to facilitate personal lifestyle choices, including services and supplies intended mainly to improve personal performance or appearance or provided primarily to beautify;
- (24) Weight control treatments, including surgical or non-surgical, whether inpatient or outpatient, including weight-control drugs;
- (25) Any eye care service or supply provided for diagnosis or treatment of astigmatism, myopia, hyperopia, or presbyopia, including eye examinations and surgery;

- (26) Eyeglasses, contact lenses, and their fitting, except when needed because of medical necessity (e.g., an injury to the eye or following cataract surgery);
- (27) Audiology (hearing) tests, unless prescribed by a physician and medically necessary;
- (28) The fitting or cost of a hearing aid;
- (29) Dental treatment except as needed because of an injury to teeth, because it is needed to treat a condition of the jaw (e.g., TMJ), or because it is necessary to surgically remove an impacted tooth, tumor, or cyst, or to drain an abscess or cyst. This exclusion includes orthodontic services, caps, crowns, prosthesis and removal, care or alignment of the teeth because of an injury to the teeth (or their surrounding tissue or structure) caused by chewing, and periodontal disease;
- (30) Routine foot care, except medically necessary orthotic devices;
- (31) Transportation or lodging, except as provided under ambulance or organ transplant benefits;
- (32) Religious counseling and marital counseling;
- (33) Treatment for compulsive gambling;
- (34) Family group therapy (e.g., parent/child relationships);
- (35) The use of CPAP's (Continuous Positive Airway Pressure) when used solely to control behavior problems or to resolve behavioral issues;
- (36) Recreational or educational therapy and other forms of non-medical self care, unless provided as a part of Plan-approved diabetic or cardiac education or rehabilitative care. This includes learning disability therapy and treatment normally provided through other mandated programs;
- (37) Wigs used for hair loss resulting from any medical condition;
- (38) Artificial insemination, invitro fertilization, pharmacy fertility agents, or treatment or drugs to reverse a sterilization procedure;
- (39) Chelation therapy that is not determined to be medically necessary (such as treatment of heavy metals);
- (40) Laetrile use in any form;

- (41) Biofeedback, massage therapy, and pain management therapy/treatment;
- (42) Treatment of drugs prescribed in connection with milieu or milieu therapy;
- (43) Services or drugs related to sex transformations;
- (44) Charges covered by automobile, homeowners, or other insurance that provide related coverage while the policy is in effect;
- (45) Ergonomic or other home or worksite evaluations;
- (46) Construction, remodeling or the structural alteration of a residence to accommodate the access to, mobility in, or use of the residence;
- (47) Genetic testing that is used as a predetermination or predictor of a *future* medical condition is not considered medically necessary and is not covered when performed in connection with the treatment or mitigation of an *existing* medical condition;
- (48) Charges for smoking cessation classes, drugs, or other treatment;
- (49) Speech, occupational, or physical therapy that is in excess of the Plan's benefit maximums without a doctor's prescription and preauthorization;
- (50) Charges for missed medical appointments;
- (51) The cost of a second procedure/surgery if it can be determined that the procedure must be redone and is necessary because physician instructions were not followed. The enrollee would be responsible for all of the cost of the second procedure and the cost of the second procedure/surgery also would not apply to the individual's annual medical out-of-pocket limit; or
- (52) The following drugs and pharmaceutical products are excluded unless otherwise noted:
 - (a) therapeutic devices or appliances, hypodermic needles (excluding those used for administration of insulin), syringes, support garments, and other non-medical substances regardless of intended use;
 - (b) any over-the-counter medication;
 - (c) blood products;
 - (d) experimental medications;
 - (e) diabetic monitors (are covered under the medical portion of the plan as Durable Medical Equipment);

- (f) contraceptive jellies, creams, foams, and devices;
- (g) cosmetic medications, including hair loss medications,
- (h) select drugs listed on the web page (riskpool.sd.gov).

We will pay benefits for incurred charges as provided for under the Plan. In the event that treatment for medical care and/or services are provided for which benefits are not otherwise payable under the Plan, the Plan, at its option, will consider the payment of benefits under the Plan for charges incurred for such care and/or services. Benefits, if any, shall be paid only as determined by the Plan.

Other Plan Provisions and Requirements

Risk Pool Administration

The Governing Board retains the right to change the Plan's design, modify coverages, and change contributions or funding mechanisms at any time it deems necessary, with appropriate notice. The Board, or other fiduciary designated, shall have authority to make a determination with respect to such issues or such provisions, subject to judicial review by a court of appropriate jurisdiction. The information contained in this document and its interpretation by the Board's designee supersedes all verbal representations of the Plan's provisions.

The Board has delegated certain tasks to its designees. When enrollees participate in the Risk Pool, they are agreeing that the Risk Pool or its designees may collect the information it needs from providers in order to make benefit determinations or payments. Providers are expected to provide needed medical and claim information to comply with this provision. It also means the Risk Pool or its designees have the right to deal directly with providers to ensure that fiduciary responsibilities are being properly carried out to achieve maximum efficiency and effectiveness.

The Risk Pool may, without the consent of or notice to any person, release to or obtain from any other person or organization any information which it deems needed to determine if a Plan provision applies.

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

Sharing information will help those providers to better evaluate and direct care. It will also allow them to provide advice to the Risk Pool as deemed reasonable in the management of the Plan and for the benefit of Plan participants.

The Risk Pool will not provide personal or medical information for commercial or marketing purposes to outside vendors.

Medically Necessary Treatment

The Risk Pool reserves the right to determine if a service or supply is medically necessary. Many services will be reviewed for appropriateness and medical necessity *before* the services are rendered, through the pre-authorization process. Other services, such as emergency care, the use of air ambulances, and private duty nursing, may be reviewed after treatment is provided.

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

Emergency Medical Treatment

The Risk Pool will provide benefits for emergency services necessary to screen and stabilize an enrollee without prior authorization if a prudent layperson would have reasonably believed that an emergency condition existed. For out-of-state preferred providers, payment for covered services will be made in accordance with the provider contract provisions. For out-of-state providers that are not preferred providers, payment will be limited to reasonable charges for covered services.

For providers which are not participating providers, treatment that is not preauthorized must be such that a prudent person reasonably believed that a delay in obtaining services would worsen the condition. Emergency services provided beyond those necessary to screen and stabilize an enrollee need to be preauthorized and will be paid in accordance with the other outlined provisions.

Claims Payment Process

Claims are paid as described in the following provisions.

Submitting a Health Claim

A claim for benefits must be made to the Risk Pool in writing within one (1) year after the end of the Plan Year in which the charges are incurred. A written claim must include the following information:

- (1) when and how the service occurred;
- (2) the name of the service provider;
- (3) the nature of the service;
- (4) the extent of the service; and
- (5) cost of the procedure(s).

Failure to furnish proof of the service received within the time limit that applies may not result in denial or reduction of a claim if it is shown:

- (1) it was not reasonably possible to provide the proof within the time limit that applies; and
- (2) the proof was provided as soon as reasonably possible.

The enrollee may acquire claim forms from the Risk Pool.

Benefit Payments

Upon receipt by the Risk Pool of a claim, benefits under the Plan are paid as follows:

- (1) The Risk Pool will pay the benefits directly to the hospital or other provider at rates provided for in South Dakota Codified Law. The Risk Pool reserves the right to refuse assignment of benefits.
Note: If an out-of-state provider that is not part of the contracted provider network is used, the enrollee is responsible for verifying that the provider will accept the Risk Pool's reimbursement and any deductible or coinsurance as payment in full. If this out-of-state provider does not accept the Risk Pool's reimbursement as payment in full, the enrollee may be held responsible for the balance of the charges.
- (2) Benefits to which the enrollee is entitled which remain unpaid at the enrollee's death are paid to the enrollee's beneficiary, if a designated beneficiary (spouse and/or other designated dependent) survives the enrollee. Otherwise, the benefits are paid to the enrollee's estate.
- (3) The Risk Pool will interpret the provisions of the Plan, make findings of fact, and assign benefit payments. Decisions by the Risk Pool are subject to a grievance on the enrollee's part to challenge denials or adverse determinations.

Coordination of Benefits

If the enrollee has a plan other than the Risk Pool plan, that plan shall be primary payor and the Risk Pool shall be the secondary payor unless otherwise required by Federal law. The Risk Pool shall reduce its benefits so the total benefits paid or provided by all plans are not more than 100% of total allowable expenses.

Claims Administrator's Right to Investigate Claims

By submitting a claim for benefits or reimbursement, the covered enrollee is certifying the information on the claim form is true and complete to the best of his or her knowledge and belief.

The enrollee is also agreeing that the Risk Pool has the right to investigate the claim, if necessary, or to contact any other organization or person to obtain additional information about the claim. This investigation may be conducted prospectively (before the claim is paid) or retrospectively (after the claim is paid).

A claim may be denied if the covered enrollee misrepresents, falsifies, or omits information necessary to process the claim.

Physical Exams and Autopsy

The Risk Pool, at its own expense, may require the enrollee whose injury, disease or pregnancy is the basis of a claim be examined by a physician chosen by the Risk Pool. The Risk Pool may require an exam as often as is reasonable while a claim is pending. In case of death, it may require an autopsy where the law does not forbid it to do so.

Managed Care Program

The Managed Care Program encompasses a number of services for which benefits are provided under the Plan. Unless the guidelines of the Managed Care Program are followed, benefits payable under the Plan shall be reduced.

Second Opinions

The Plan covers physician consultation services when incurred as a result of voluntary second surgical opinions or other requirements of the Plan's Managed Care Program. Voluntary second opinions are subject to the same deductible and coinsurance provisions that apply for any other surgical or medical procedures under the Plan.

The Risk Pool may require second opinions for certain covered services (such as nonemergency surgical procedures) when there is cause to believe there is an effective and equivalent alternative to the original medical/surgical opinion. (Nonemergency surgical procedures include, but are not limited to, anterior/lateral disc fusion or elective surgeries.) Second opinions are also required for surgical procedures that must be redone because the patient did not follow physician instructions.

Preauthorization or Pre-notification of Service

For non-emergency hospital admissions, and certain services listed within this document that require prior plan approval, or pharmaceuticals that require plan approval as may be communicated to an enrollee by the plan, the enrollee or provider must call the prior approval entity listed on the identification card.

Except in the case of a medical emergency, the plan will require all out-of-state care for inpatient and outpatient services to be prior authorized. Requests for out of state referrals must be made prior to receiving care from the provider to ensure the highest

level of benefits. Requests for out-of-state care will be declined if the patient care can be provided safely and cost effectively in South Dakota.

If the health condition is of an urgent nature, the enrollee must explain the urgency of the situation and request an expedited review. Expedited reviews will be handled as soon as reasonably possible. In the case of concurrent urgent care situations, where treatment is already being received, such as an emergency admission, call the prior approval entity within 48 hours of beginning treatment or as soon as reasonably possible.

The enrollee can expect to receive a written determination regarding the request for services or treatments from the prior approval entity or its designee. Expedited determinations may be provided via telephone or fax. If the review determination is adverse to the enrollee, the enrollee may appeal by following the procedures under "Appeals and Legal Action."

Failure to Preauthorize

If pre-authorization or managed care program requirements are not satisfied the enrollee's coinsurance increases to 50% of allowable and covered charges. These charges will not apply to the enrollee's annual medical out-of-pocket limit.

Other Services Requiring Preauthorization and/or Second Opinions

The services listed below also require preauthorization and/or second opinions.

Admissions

- (1) Surgical, non-surgical (medical, mental health, substance abuse), and maternity;
- (2) Skilled nursing;
- (3) Rehabilitation;
- (4) Hospice;
- (5) Transplantation services;
- (6) Observation services;
- (7) Assistant surgical services (whether performed inpatient or outpatient); and
- (8) Mental health and chemical dependency, including partial or half-time residential treatment;

Outpatient

- (1) Surgical procedures performed at the outpatient department of ambulatory surgical centers, hospitals, or specialty hospitals, including but not limited to procedures such as sinus surgery, mastectomy, breast repair and/or reconstruction, arthroscopy, tonsillectomy, cataract removal, and tympanostomy (ear tubes);

- (2) Select diagnostic procedures, including cardiac catheterization and MRIs, PET, and CT scans;
- (3) TMJ services;
- (4) Home health services, including home intravenous, pain management, and hospice;
- (5) Diabetes and cardiac self-management training and education;
- (6) Ambulatory infusion;
- (7) Rehabilitation;
- (8) Speech, occupational, or physical therapy in excess of 10 treatments;
- (9) Transplantation services;
- (10) Chelation therapy;
- (11) Overnight observation services;
- (12) Assistant surgical services when those services are not generally accepted practice in an outpatient setting;
- (13) Select durable medical equipment, services, and supplies:
 - (a) Contact lens
 - (b) Compression pumps
 - (c) CPAP, Bi-Pap, CPAP with humidifier
 - (d) CPM
 - (e) Custom made braces over \$1,000
 - (f) Electrical stimulation for urinary/bowel incontinence
 - (g) Erect aid
 - (h) Feeding pump (pump and kit)
 - (i) Hospital beds
 - (j) Insulin pumps
 - (k) Intermittent urinary catheters
 - (l) Neuromuscular electrical stimulators
 - (m) Negative pressure wound therapy pump
 - (n) Osteogenic stimulator (bone growth stimulator) — authorization requires a physician's documented history of poor bone healing and at least one risk factor (such as multi-level fusion, smoker, or diabetes)
 - (o) Oximeters
 - (p) Oxygen (includes the oxygen carrier)
 - (q) Percussors
 - (r) Pressure relief mattress
 - (s) Prosthetics
 - (t) SADD lights
 - (u) Suction pumps
 - (v) TENS (transcutaneous electrical nerve stimulator)
 - (w) Terbutaline pumps
 - (x) Uterine monitor

- (y) Ventilators
 - (z) Wheelchairs for purchase
- (14) Select drugs listed on the web page (riskpool.sd.gov)

Disease Management and Other Follow-Up Programs

Enrollees who have been identified as having a chronic condition or as being at high risk for certain conditions are required to join special follow-up programs. If the plan determines that you are not complying with your disease management program(s), notice will be given to you and a time frame will be provided in that notice for you to comply with the disease management program. If you fail to comply after the time frame given in the notice, your benefits will be reduced to 50%. There is no annual out-of-pocket limit for the enrollee when this occurs. If after your benefits have been reduced you come in to compliance with your disease management programs for a period of at least 2 months, full benefits will be reinstated from that date forward.

Tobacco Use

Failure to accurately disclose tobacco use is cause for non-renewal or at the option of the Plan, to allow continued coverage with the enrollee being responsible for paying the appropriate premiums including those due retroactively. Once an enrollee has been tobacco free for 12 consecutive months, they may contact the Risk Pool Administrator in writing to request a mitigation of premium rates to a 'non-tobacco' user status. The Plan reserves the right to verify an enrollee's claim regarding tobacco use through medical means at the expense of the plan.

Appeals & Legal Action

The enrollee can expect to receive an explanation of benefits (EOB) when a claim for benefits is denied in whole or in part, that states the specific reason for the denial. An address that the enrollee may send an appeal review request and any supporting documentation or comments to should be included.

The enrollee can expect to receive an acknowledgement of the review request and a written decision within 30 days of receipt of the appeal. If a determination can't be made within this time period, an extension may be taken with prior notice given to the enrollee.

If the appeal is denied, the enrollee may request an appeal of the decision in writing to the Director of Benefits within 30 days of receipt of the decision. The enrollee can expect to receive a written decision within 30 days of receipt of the appeal. If the Director of Benefits denies the appeal, the enrollee may appeal in writing to the Risk Pool Board within 30 days of receipt of the decision. The enrollee can expect to receive written notice of the Board's decision.

For issues not related to an adverse claim determination, an enrollee may request an appeal directly from the Director of Benefits in writing within 180 days of the decision. The enrollee can expect to receive a written decision within 30 days from the Director of Benefits. If the enrollee does not agree with the Director's decision, a written appeal request can be sent to the Risk Pool Board within 30 days of the date of that decision. The enrollee can expect to receive written notice of the Board's decision.

The plan or the enrollee may appeal the decision of the Board to circuit court in accordance with SDCL 1-26. No legal action or suit to recover from the Plan may be started before 60 days after written proof of loss has been furnished. Further, no legal action or suit may be brought more than 3 years after the time proof of loss must be furnished.

Subrogation

Occasionally, benefits are paid under the Plan for charges incurred by the enrollee as a result of injury or disease that may have been caused by another party. If this happens, the Plan is subrogated, unless otherwise prohibited by law, to the rights of recovery that the enrollee may have against any person or organization who may acknowledge liability or be found liable by a court of competent jurisdiction for the injury or disease.

The enrollee will be required to reimburse the Plan out of any monies the enrollee receives from any other person or organization as a result of judgment, settlement, or otherwise. The enrollee will not be required to reimburse the Plan more than the amount the enrollee recovers for the injury or disease.

Subrogation rights apply only to the extent that benefits are paid under the health coverages of the Plan. Any fees and costs associated with the recovery shall be borne by the Risk Pool.

The Plan also reserves the right to pursue recovery from the third party at its discretion should the enrollee decide not to attempt recovery. The enrollee must notify the Risk Pool or the Risk Pool's Claims Administrator immediately about any injury or illness that may have been caused by a liable third party.

Right to Recovery

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

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

Assignment

The Risk Pool retains the right to assign or to refuse assignment of benefits to providers.

Severability

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

Contact Information

Risk Pool Administration: To contact a party that can answer your questions concerning the Risk Pool Plan.

South Dakota Risk Pool
c/o Bureau of Personnel
500 East Capitol
Pierre, SD 57501

Phone: 605.773.3148
Fax: 605.773.6840
Email: riskpool@state.sd.us
Website: riskpool.sd.gov

Claim Processing: To contact the claims processor that can answer your questions about claims and payments.

SD Risk Pool
c/o DakotaCare
2600 W. 49th Street
PO Box 7406
Sioux Falls, SD 57117

Phone: 1.800.831.0785
Fax: 605.274.3290
Website: www.dakotacare.com

Preauthorization: To preauthorize services and admissions or to contact the disease management provider about requirement.

Dr. Michael Pekas, Medical Director
Health Care Medical Technologies, Inc.

2301 W. Russell
Sioux Falls, SD 57104

Phone: 1.877.227.3100
Fax: 605.731.1905
Email: mpekas@hcmti.com
Website: www.hcmti.com

Pharmacy Plan: To preauthorize a prescription or to contact the pharmacy benefit manager.

Express Scripts
Phone: 1.877.212.9529
Website: www.express-scripts.com

Definitions

- (1) **“Acute Rehabilitation Facility”** means an institution operated pursuant to law for the purpose of providing Rehabilitation Therapy.
- (2) **“Biologically-Based Mental Illness”** The term biologically-based mental illness means schizophrenia and other psychotic disorders, bipolar disorder, major depression, and obsessive-compulsive disorder.
- (3) **“Claims Administrator”** means the person or persons designated by the Risk Pool to receive, process, and determine all claims submitted by enrollees. Currently, DAKOTACARE is the Claims Administrator for the Risk Pool.
- (4) **“Custodial Care”** means a level of care which:
 - (a) Cannot reasonably be expected to greatly restore health;
 - (b) Is mainly made up of non-skilled nursing services; and
 - (c) Is chiefly designed to assist a person in coping with the activities or problems of daily living — such as training or assistance with personal
 - (d) Hygiene and other self-care activities. (Custodial care may be given in an at-home setting or in a nursing home or extended care facility.)
- (5) **“Durable Medical Equipment” (DME)** is equipment that is designed primarily for use in a hospital for treatment and cure of a medical condition but is prescribed for use in the home. Durable medical equipment may include an iron lung, an

oxygen tent, a hospital bed, a wheelchair, and other similar types of durable medical equipment. It does not include exercise equipment, nor does it include sauna, whirlpool, or similar devices.

- (6) **“Extended Care Facility (ECF)”** means an institution, which:
- (a) Is operated pursuant to law;
 - (b) Is approved as a skilled nursing facility for payment of Medicare benefits or qualified to receive that approval, if requested;
 - (c) Is primarily engaged in providing room and board and skilled nursing care under supervision of a physician;
 - (d) Provides continuous 24 hour a day skilled nursing care by or under supervision of a registered nurse (RN); and
 - (e) Maintains a daily medical record of each patient.

Coverage under this Plan at an ECF is limited to sixty (60) days per Plan Year.

A home, facility or part of a facility does not qualify as an ECF if it is used primarily for:

- (a) Rest;
 - (b) The care of drug abuse or alcoholism;
 - (c) The care of mental diseases or disorders; or
 - (d) Custodial or educational care.
- (7) **“Home Health Agency”** means:
- (a) An agency certified as a home health agency by the State where care was provided; or
 - (b) An agency certified as such under Medicare; or
 - (c) An agency approved as such by the Risk Pool.
- (8) **“Home Health Care”** means health services and supplies provided to a covered person on a part-time, intermittent, visiting basis. These services and supplies must be provided in a person’s place of residence while the person is confined as a result of injury, disease, or pregnancy. Also, a physician must certify that the use of these services and supplies is to treat a condition as an alternative to confinement in a hospital or extended care facility.
- (9) **“Home Health Care Plan”** means a plan of care established and approved in writing by a physician.
- (10) **“Hospital”** means an institution which:
- (a) Is operated pursuant to law for the provision of medical care;
 - (b) Provides continuous 24 hour a day nursing care under the supervision of a staff of physicians;
 - (c) Has facilities for providing diagnostic and therapeutic services to diagnose, treat, and care for injured, disabled, or sick individuals who need acute inpatient care;
 - (d) Has facilities for major surgery; and

(e) If required, is licensed as a hospital.

But, an institution primarily concerned with the treatment of chronic disease does not need to have facilities for major surgery, if it otherwise qualifies, as provided above.

“Hospital” also means Critical Access Hospitals, or Specialized Hospitals and an ambulatory surgical center which is operated pursuant to law, including licensed mobile units.

For treatment of alcoholism and drug abuse only, **“hospital”** also means:

- (a) A treatment or residential facility; or
- (b) A clinic.

Such facilities must be licensed or approved by the appropriate authority for these purposes in the jurisdiction in which they are located.

“Hospital” does not include a:

- (a) Rest home;
- (b) Nursing home;
- (c) Convalescent home;
- (d) Place for custodial care;
- (e) Home for the aged;
- (f) Institution that primarily furnishes training for medical students; or
- (g) A doctor’s office or clinic which is equipped to perform minor surgery.

(11) A **“Hospital Stay”** occurs if a person:

- (a) Incurs a hospital room and board charge for medically necessary inpatient care, whether for observation or treatment;
- (b) Undergoes surgery at a hospital; or
- (c) Is treated for alcoholism or drug abuse at a hospital.

Unless it is an emergency or a “normal” maternity admission, inpatient hospital stays must be preauthorized by the Risk Pool’s current Health Care Management Company **before** the patient is hospitalized.

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

(13) **“Medical Emergency”** means:

- (a) The sudden and unexpected onset of a medical condition; and

- (b) Such condition causes the person to seek medical care and treatment promptly or within a reasonable time after the onset.
- (14) **“Medically Necessary”** means that a service or supply meets all of the requirements that are listed below:
- (a) It must be legal.
 - (b) It must be ordered by a physician.
 - (c) It must be necessary to meet the basic needs of the covered person and safe and effective in treating the condition for which it is ordered.
 - (d) It must be part of a course of treatment which is FDA approved and generally accepted by the American medical community. That community includes all of the branches, professional societies, and governmental agencies therein.
 - (e) It must be rendered in a cost-effective manner; in a setting or location that is appropriate for the delivery of those health services; and in the proper quantity, frequency, and duration for treatment of the condition for which it is ordered.
 - (f) It must be required for reasons other than:
 - (1) custodial care (to help the patient with the daily activities of living);
 - (2) the personal comfort or convenience of the covered person, of his or her family, or of the physician; and
 - (3) of demonstrated value.
 - (g) It must not be redundant when it is combined with other services and supplies that are used to treat the condition for which it is ordered.
 - (h) It must not be experimental or investigative.
 - (i) Its primary purpose must be to restore health and extend life. Services or supplies that are prescribed mainly for cosmetic reasons, to alleviate symptoms, or to facilitate personal lifestyle choices are not considered medically necessary.
- (15) **“Pharmacy Network”** means a group or groups of pharmacies who have contracted with the Risk Pool to provide services to Plan participants and who the Risk Pool has designated as participating, or network, providers. Currently, pharmacies participating in the Express Scripts pharmacy network are considered participating pharmacies.
- (16) **“Pre-existing Condition”** means an illness, injury, or condition for which any professional medical advice, diagnosis, care, or treatment was recommended or received during the six-months immediately preceding the effective date of coverage. The pre-existing condition does not apply to pregnancy, to a newborn child who is covered under this Plan within 30 days of birth, or to a child who is adopted or placed for adoption, and who, as of the last day of the 30 day period, beginning on the date of adoption or placement for adoption is covered under this Plan.
- (17) **“Pre-Existing Waiting Period”** – The six months immediately following the enrollment date during which pre-existing conditions are not covered.
- (18) **“Physician”** means one who is licensed as such while acting within the scope of that practice.

- (19) **“Pregnancy”** includes the condition of being pregnant and childbirth as well as related medical conditions
- (20) **“Rehabilitation Therapy”** means a series of procedures or treatments provided in a hospital, ECF or acute rehabilitation facility which will enable an injured or ill person to carry on the regular and customary activities of a person of the same age and sex.
- (21) **“Surgical Procedure”** means:
- (a) a cutting procedure;
 - (b) suturing of a wound;
 - (c) treatment of a fracture;
 - (d) reduction of a dislocation;
 - (e) radiotherapy, excluding radioactive isotope therapy, if used in lieu of a cutting operation for removal of a tumor;
 - (f) electro cauterization;
 - (g) diagnostic and therapeutic endoscope procedures; and
 - (h) an operation by means of laser beam.
- (22) **“Utilization Review Organization”** (Health Care Management Company) means the independent entity, group, or individual selected by the Risk Pool to carry out the Managed Care Program. Currently, Health Care Medical Technology (HCMT) is the Risk Pool’s Health Care Management Company and Utilization Review Organization for medical services, treatment and supplies. At its discretion, the Risk Pool may designate some other company to perform this function.

**South Dakota Risk Pool
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. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

The **South Dakota Risk Pool** is required to provide all participants with this Notice of Privacy Practices and to explain your rights and the Risk Pool’s legal duties concerning your medical information under federal law. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect August 1st, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and send the new notice to our health plan contract holders at the time of the change.

How the Plan Uses and Discloses Health Care Information

There are some services the Plan provides through contracts with private companies. For example, Dakotacare Administrative Services administers most medical claims to your health care providers. When services are contracted, the Plan may disclose some or all of your information to the company so that they can perform the job the Plan has asked them to do. To protect your information, the Plan requires the company to safeguard your information in accordance with the law.

The following categories describe different ways that the Plan uses and discloses your health information. For each category, we will explain what we mean and give an example.

- **For payment:** The Plan may use and disclose information about you so that it can authorize payment for the health services that you received. For example, when you receive a service covered by the Plan, your health care provider sends a claim for payment to the claims administrator. The claim includes information that identifies you, as well as your diagnoses and treatments.
- **For medical treatment:** The Plan may use or disclose information about you to ensure that you receive necessary medical treatment and services. For example, if you participate in a Disease Management Program, the Plan may send you information about your condition.
- **To operate various Plan programs:** The Plan may use or disclose information about you to run various Plan programs and ensure that you receive quality care. For example, the Plan may contract with a company that reviews Hospital records to check on the quality of care that you received and the outcome of your care.
- **To other government agencies providing benefits or services:** The Plan may give information about you to other government agencies that are giving you benefits or services. The information must be necessary for you to receive those benefits or services.
- **To keep you informed:** The Plan may mail you information about your health and well-being. Examples are information about managing a disease that you have, information about your managed care choices, and information about Prescription drugs you are taking.

- **For overseeing health care providers:** The Plan may disclose information about you to the government agencies that license and inspect medical facilities, such as Hospitals, as required by law.
- **For research:** The Plan may disclose information about you for a research project that has been approved by a review board. The review board must review the research project and its rules to ensure the privacy of your information. The research must be for the purpose of helping the Plan.
- **As required by law:** The Plan will disclose information about you as required by state or federal law.
- **Disaster Relief:** We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.

Public Benefit: We may use or disclose your medical information as authorized by law for the following purposes deemed to be in the public interest or benefit:

- For public health activities, including disease and vital statistic reporting, child abuse reporting, FDA oversight, and to employers regarding work-related illness or injury;
- To report adult abuse, neglect, or domestic violence;
- To health oversight agencies;
- In response to court and administrative orders and other lawful processes;
- To law enforcement officials pursuant to subpoenas and other lawful processes, concerning crime victims, suspicious deaths, crimes on our premises, reporting crimes in emergencies, and for purposes of identifying or locating a suspect or other person;
- To coroners, medical examiners, and funeral directors;
- To organ procurement organizations;
- To avert a serious threat to health or safety;
- To the military and to federal officials for lawful intelligence, counterintelligence, and national security activities;
- To correctional institutions regarding inmates; and
- As authorized by state worker's compensation laws.

On your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

To your family or friends: We may disclose your medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care. We may use or disclose your name, location, and general condition or death to notify, or assist in the notification of a person involved in your care.

Your Rights

Access: You have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you a cost-based fee for staff time to locate and copy your medical information, and postage if you want the copies mailed to you. If you

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes other than treatment, payment, health care operations, as authorized by you, and for certain other activities, since August 1, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for the disclosure, and certain other information. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). Any agreement to additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.

Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. You must make your request in writing, and you must state that the information could endanger you if it is not communicated in confidence as you request. We must accommodate your request if it is reasonable, specifies the alternative means or location, and continues to permit us to collect premiums and pay claims under your health plan, including issuance of explanations of benefits to the contract holder of the health plan in which you participate. An explanation of benefits issued to the contract holder for health care that you received for which you did not request confidential communications or about the contract holder or others covered by the health plan in which you participate may contain sufficient information to reveal that you obtained healthcare for which we paid, even though you requested that we communicate with you about that health care in confidence.

Amendment. You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request if we did not create the information you want amended and the originator remains available or for certain other reasons. If we deny your request, we will provide you a written

explanation. You may respond with a statement of disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.

Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

For More Information or to make a Complaint

If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Office:

Mailing Address: South Dakota Risk Pool
c/o Bureau of Personnel
500 Capitol Avenue
Pierre, S.D. 57501

Telephone: 605.773.3148

Fax: 605.773.6840

Email: riskpool@state.sd.us

Web Site: riskpool.sd.gov