South Dakota State Employee Health Plan

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

FY 2011

Group Term Life Plan

This combined Summary Plan Description and Plan Document describes the flexible benefits program available to eligible Employees of the State of South Dakota (the "State") under the South Dakota State Employee Health Plan (the "Plan") on or after their effective date(s) for participation.

The State offers its eligible Employees a cafeteria plan intended to satisfy the requirements of Internal Revenue Code Sections 106, 125, 129 and 105(e), to provide Employees medical and Dependent care FSAs and the opportunity to make pre-tax contributions toward certain benefits. The cafeteria plan is for Employees only. Under this cafeteria plan, you may elect to have your cost for Health, Dental Care, Vision Care, Hospital Indemnity Plan, Medical Expense Spending Account, and Dependent Care Spending Account and Health Savings Account, deducted from your pay on a before-tax basis. The Health Plan is described in the South Dakota State Employee Health Plan Summary Plan Description and Plan Document for the Health Plans. This means your contributions come out of your pay before federal income and employment taxes are deducted. Before-tax contributions reduce your gross salary, which lowers your taxable income and, therefore the amount of income tax you must pay. By paying lower taxes, you save money. Contributions may, however, be subject to state or local income taxes.

The description in this Summary Plan Description Document does not imply that you have enrolled in these Plans. Your enrollment in any or all of these benefits is determined by records maintained by the Bureau of Personnel. As Plan Administrator, the Bureau of Personnel has final authority to make determinations on eligibility, enrollment, and issues not specifically addressed in Plan provisions, ambiguously written provisions, or verbal representations that appear to conflict with any section of this official Summary Plan Description Document. The information contained in this Summary Plan Description Document and its interpretation by the Plan Administrator (the Bureau of Personnel) or the Plan Administrator designee supersedes all verbal representations of the Plan provisions and will govern in all cases.

The Plan is established with the intention of being maintained for an indefinite period of time; however, the State of South Dakota, in its sole discretion and in accordance with the Plan Amendment and Termination section set forth below may amend or terminate any of the benefit programs or any provision of the Plan at any time. No termination or amendment shall operate to reduce the amount of any benefit payment under the Plan for charges incurred prior to the effective date of such termination or amendment.

This Document does not create a contract or guarantee of employment between the State of South Dakota Bureau of Personnel and any individual. Your employment is always on an at-will basis. The State of South Dakota or you may terminate the employment relationship without notice at any time and for any reason.

If you have any questions about this Document or certain provisions of the plan, please call Bureau of Personnel, Benefits Program at 605.773.3148 or 1.877.573.7347.

HIPAA PRIVACY AND SECURITY

This section describes the manner in which the Plan will protect certain health information used or maintained by the Plan.

The Company sponsors and maintains certain group health plans that are subject to the Health Insurance Portability and Accountability Act of 1996, ("HIPAA") regulations as are described more fully in this Document. Under the privacy and security rules of HIPAA, and the regulations issued thereunder at 45 CFR Parts 160 and 164 ("the HIPAA regulations"), a group health plan must: (i) restrict the use and disclosure of protected health information ("PHI"), (ii) ensure the confidentiality, integrity, and availability of all electronic protected health information ("e-PHI") the plan creates, receives, maintains, or transmits, (iii) protect against any reasonably anticipated threats or hazards to the security and integrity of such information, (iv) protect against any reasonably anticipated uses or disclosures of such information that are not permitted or required under the HIPAA privacy rules set forth in 45 CFR Part 164, Subpart E, and (v) ensure compliance with the HIPAA security rules set forth in 45 CFR Part 164, Subpart C by its workforce;

1. **Uses and Disclosures of PHI.** The Plan and the Company may disclose a Plan Member's PHI to the Company (or to the Company's agent) for the Plan administration functions described under 45 CFR 164.504(a), to the extent not inconsistent with the HIPAA regulations.

2. **Restriction on Plan Disclosure to the Company.** Neither the Plan nor any of its Business Associates, health insurance issuers, or HMOs, will disclose PHI to the Company except upon the Plan's receipt of the Company certification that the Plan has been amended to incorporate the agreements of the Company under paragraph 3, except as otherwise permitted or required by law.

3. **Privacy Agreements of the Company.** As a condition for obtaining PHI from the Plan, its Business Associates, Insurers, and HMOs, the Company agrees it will:

   a. Not use or further disclose such PHI other than as permitted by paragraph 1 of this section, as permitted by 45 CFR 164.508, 45 CFR 164.512, and other sections of the HIPAA regulations, or as required by law;

   b. Ensure that any of its agents, including a subcontractor, to whom it provides the PHI agree to the same restrictions and conditions that apply to the Company with respect to such information;

   c. Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or Employee benefit plan of the Company;

   d. Report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided for of which the Company becomes aware;

   e. Make the PHI of a particular Member available for purposes of the Member's requests for inspection, copying, and amendment, and carry out such requests in accordance with HIPAA regulation 45 CFR 164.524 and 164.526;

   f. Make the PHI of a particular Member available for purposes of required accounting of disclosures by the Company pursuant to the Member's request for such an accounting in accordance with HIPAA regulation 45 CFR §164.528;

g. Make the Company's internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;

h. If feasible, return or destroy all PHI received from the Plan that the Company still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Company agrees to limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

i. Ensure that there is adequate separation between the Plan and the Company by implementing the terms of subparagraphs (1) through (3), below:

(1) *Employees With Access to PHI*: The following Employees or other individuals under the control of the Company are the only individuals that may access PHI received from the Plan:

Commissioner
Director
Legal Counsel
Assistant Director
Personnel Specialists III
Accountant
Personnel Specialist
Senior Secretary

(2) *Use Limited to Plan Administration*: The access to and use of PHI by the individuals described in (1), above, is limited to Plan Administration functions as defined in HIPAA regulation 45 CFR §164.504(a) that are performed by the Company for the Plan.

(3) *Mechanism for Resolving Noncompliance*. If the Company or any other person(s) responsible for monitoring compliance determines that any person described in (1), above, has violated any of the restrictions of this section, then such individual shall be disciplined in accordance with the policies of the Company established for purposes of privacy compliance, up to and including dismissal from employment. The Company shall arrange to maintain records of such violations along with the persons involved, as well as disciplinary and corrective measures taken with respect to each incident.

4. **Security Agreements of the Company.** As a condition for obtaining e-PHI from the Plan, its Business Associates, Insurers, and HMOs, the Company agrees it will:

a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan;

b. Ensure that the adequate separation between the Plan and the Company as set forth in 45 CFR 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information;

d. Report to the Plan any Security Incident of which it becomes aware. For purposes of this section, "Security Incident" shall mean successful unauthorized access to, use, disclosure, modification or

destruction of, or interference with, the e-PHI; and

e. Upon request from the Plan, the Company agrees to provide information to the Plan on unsuccessful unauthorized access, use, disclosure, modification or destruction of the e-PHI to the extent such information is available to the Company.

5. **PHI not Subject to this Section**. Notwithstanding the foregoing, the terms of this section shall not apply to uses or disclosures of Enrollment, Disenrollment, and Summary Health Information made pursuant to 45 CFR 164.504 (f)(l)(ii) or (iii); of PHI released pursuant to an Authorization that complies with 45 CFR 164.508; or in other circumstances as permitted by the HIPAA regulations; provided however that paragraph 4 above shall apply if and only if e-PHI beyond enrollment, disenrollment, summary health information, and authorized disclosures is obtained by the Company, and the Company adopts the literal interpretation of 45 CFR 164.314(b)(1), which would apply paragraph 4 unless the only e-PHI obtained is enrollment, disenrollment, summary health information, or authorized disclosures.

6. **Definitions.** All capitalized terms within this section not otherwise defined by the provisions of this section shall have the meaning given them in the respective Plan or, if no other meaning is provided in the Plan, the term shall have the meaning provided under HIPAA.

If you have any questions about this Document or certain provisions of the plan, please contact:

BUREAU OF PERSONNEL	All benefit related questions
PMB 0141-1 500 East Capitol Avenue Pierre, SD 57501	Email: bopinfo@state.sd.us Web site: http://benefits.sd.gov
605.773.3148 1.877.573.7347	Press 1 for DAKOTACARE 2 for Bureau of Personnel 3 for HealthFitness 4 for Delta Dental 5 for HMP

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MASTER SCHEDULE

SOUTH DAKOTA
STATE EMPLOYEE BENEFITS PROGRAM

(Administered by the Commissioner of the Bureau of Personnel of the State of South Dakota)

Effective Date:	July 1, 2010
Eligible Class:	All Benefit Eligible Employees, Retired Employees, and participants eligible for Continuation Coverage.
Waiting Period:	One month and one day from the date of hire.
Eligible Dependents:	Dependents of Benefit Eligible Employees as defined in Section 2.

Other Important Information

How Medical Information About You May Be Used and Disclosed and How You Can Get Access to This Information

Our Legal Duty
As a participant in the South Dakota State Employees Benefits Plan, the Plan is required to provide you with this Notice of Privacy Practices and to explain your rights and the legal duties of the Plan concerning your medical information under federal law. The Notice of Privacy Practices is located at http://benefits.sd.gov , under Active, Forms and Documents, and click on HIPAA Privacy Notice. The Plan must follow the privacy practices which are described in this notice, effective on April 14, 2003, and revised on March 31, 2006. 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.

MASTER SCHEDULE

BASIC LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE FOR ELIGIBLE EMPLOYEES

Basic Life Coverage of $25,000 is available for all Benefit Eligible Employees. This coverage includes both a group term life and an accidental death and dismemberment (AD&D) benefit. The AD&D coverage provides a life benefit in the case of accidental death plus a benefit.

BENEFIT FOR BASIC LIFE	ADDITIONAL AD&D BENEFIT FOR BASIC LIFE	TOTAL
$25,000	$25,000	$50,000

Any change in amounts of coverage due to change in Eligibility shall take effect on the first payroll date following the Eligibility change.

SUPPLEMENTAL LIFE BENEFIT FOR ELIGIBLE EMPLOYEES

In addition to the Basic Life benefit, the Employee may choose Supplemental Life Coverage equal to two, three, four, or five times annual earnings to a maximum of $400,000. To determine the amount of coverage, annual earnings will be rounded to the next higher multiple of $1,000 if they are not an even multiple of $1,000.

Note: See rates in the Section 4.2.

OPTIONAL LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE FOR DEPENDENTS

An Employee must elect Supplemental Life Coverage in order to purchase Dependent Life Coverage. An Employee may purchase $10,000 of Dependent Life Coverage for each of the Employee's eligible Dependents. (See the definition of Dependent in Section 2.)

Eligible Dependents include the Employee's spouse and dependent children. Coverage for dependent children begins 14 days after birth and generally ends in the month of the child's 29th birthday. Coverage continues until the last day of the month in which the Dependent is no longer eligible. (See the definition of Dependent in Section 2 for eligibility requirements.)

Dependent Life Coverage includes both a life benefit and an AD&D benefit. This coverage applies to all eligible dependents.

	LIFE BENEFIT FOR DEPENDENTS	ADDITIONAL AD&D BENEFIT FOR DEPENDENTS	TOTAL
Dependent Life Coverage	$10,000	$10,000	$20,000

WORDS AND PHRASES

Some terms used in the Plan are defined below. Other terms may be explained where used in another part of the Plan.

(a) **"Active Employee" -** An Employee who reports to work or is able to report to work at the Employee's usual place of employment and is able to perform the essential functions of the Employee's job.

(b) **"Actively at Work" -** An employee is Actively at Work if the employee:

1) reports for work at the Employee's usual place of employment ("usual place of employment" includes work performed outside of the Employee's home and work done from home by telecommuting — as long as the Employee can record hours worked on his or her timesheet, regardless of location, and the employer agrees to the working arrangement); and

2) is able to perform all of the essential (usual and customary) duties of such Employee's occupation on a regular full-time basis.

An Employee who does not report for work or whose usual place of employment is in the home shall be considered "Actively at Work," if, at any time on the date in question, the Employee is neither:

1) a hospital patient; nor

2) disabled to a degree that the Employee could not have reported to a place of employment outside of the home and performed all of the usual and customary duties of the person's occupation on a regular full-time basis.

(c) **"Annual Earnings" -** Base annual salary and does not include any other compensation such as longevity pay, fringe benefits, bonuses, overtime pay, or summer school compensation.

(d) **"Coverage" -** All of the terms and provisions appearing under the section providing the particular kind of coverage.

(e) **"Dependent"** Means the following, as long as such person is not otherwise eligible to be covered as an Employee under the Plan; or, if such person was previously eligible, is no longer eligible because of a disability.

1) the Employee's spouse who is not divorced or legally separated from the Employee as recognized by Federal and South Dakota Law;

2) Each of the Employee's children who is:

a) unmarried;

b) under the age of 19 or under the age of 29 if a full-time student. For purposes of life coverage, benefits shall cease for a Dependent Child on the last day of the month in which each child attains age 19, or age 29 if a full-time student if applicable premium is paid;

c) not employed on a regular full-time basis; and

d) not in military service.

The term "children" means children by birth, adopted children, children who have been placed for adoption, stepchildren, or children who live with the Employee in a legal parent-child relationship (legal guardianship).

Newborn children may be covered at birth provided the Plan is notified within 90 days of the birth and the appropriate premium is paid.

The following individuals are not included in the definition of Dependent except under special COBRA qualifying conditions:

- ex-spouse(s) of Employee;
- married children of Employee;
- children of Employee who are employed full-time; and
- children of Employee who are serving in the military.

"Dependent Children" – Children who meet the definition of "Dependent" include children by birth, adopted children, children who have been placed for adoption, stepchildren, or children who live with the Employee in a legal parent-child relationship (legal guardianship).

Newborn children may be covered at age 14 days provided the Plan is notified within 90 days of the birth and the appropriate premium is paid.

Notwithstanding the above, "Dependent Children" also include an eligible Employee's child named as an alternate recipient with respect to such eligible Employee under a medical support order (as defined in ERISA Section 609(a) (2) (A)).

(f) **"Eligible Employee" -** An active Employee placed in a permanent position, employed by a participating agency and scheduled to work 20 or more hours a week at least six months of the year.

(g) **Full-Time Employee" -** An active Employee who has been placed in a permanent classification of Employees, employed by a participating unit and scheduled to work 20 or more hours a week at least six months of the year.

(h) **"Injury" -** Bodily injury sustained accidentally by external means.

(i) **"Legal Guardian" -** A person appointed by a court to be responsible for the personal affairs of a minor or protected person.

(j) **"Occupational Disease" -** A disease for which a person is entitled to benefits under a Workers' Compensation Law or similar law.

(k) **“Occupational Injury” -** An injury which arises out of and in the course of employment for wage or profit. An injury will not be deemed occupational if such person is not eligible for Workers’ Compensation coverage when the injury occurs.

(l) **“Qualified Domestic Relations Orders (QDRO)” -** A "qualified domestic relation order" is a domestic relations order (i.e. child support, alimony payments) that creates or recognizes the existence of an alternate payee's right to receive, or assigns to an alternate payee the right to receive, all or a portion of the benefits payable with respect to a participant under a retirement plan, and that includes certain information and meets certain other requirements.

(m) **“Qualified Medical Child Support Order (QMCSO)” -** A qualified medical child support order is a court order used to enforce an order for a health plan participant to provide child support health benefits. It requires a health plan to include a child as covered under a health plan, even if the child(ren) or the participant do not meet the conditions of the health plan. A QMCSO is typically used to gain coverage for a child under a non-custodial parent's group health plan. It is normally obtained by a divorced or separated spouse or by a state child support or Medicaid agency. The order authorizes withholding the participant's share of the cost for coverage from their pay. They may not drop coverage for the child without proof that the QMCSO is no longer in effect.

(n) **“Retired Employee” –** A former Employee who is covered under the health coverage plan provided under SDCL 3-12A on his or her date of retirement. The Retired Employee must also be entitled to immediate retirement benefits as a Class A or Class B member of the South Dakota Retirement System or the South Dakota Department of Labor Retirement Plan as outlined in SDCL 3-12-91, SDCL 3-12-92, and SDCL 61-2-15.

(o) **“Spouse” -** An Employee’s husband or wife as the result of a marriage that is legally recognized in the state of South Dakota. The Spouse in a common-law marriage is not an Eligible Dependent.

(p) **“Total Disability” -** means the Employee is permanently and continuously disabled by injury or disease to the extent the Employee cannot work for pay or profit and is not able to take part in any business or occupation.

(q) **“Written Notice” -** A notice in writing on a form supplied by or which satisfies the Plan Administrator.

ELIGIBILITY AND APPLYING FOR COVERAGE – BASIC LIFE COVERAGE FOR EMPLOYEES

Some terms used in General Provisions are defined below. Others may be explained in the "Words and Phrases" section.

WHO MAY BECOME COVERED – BASIC LIFE COVERAGE FOR EMPLOYEES

A Benefit Eligible Employee is automatically eligible for Basic Life Coverage. A Benefit Eligible Employee is considered eligible on the latest of:

(a) completion of any applicable Waiting Period;

(b) the date the Employee is included in the Eligible Class; or

(c) the Effective Date.

AMOUNT OF BASIC LIFE COVERAGE

A Basic Life Coverage of $25,000 is provided to Benefit Eligible Employees by the State of South Dakota.

APPLICATION FOR BASIC LIFE COVERAGE

An Employee must complete the online Group Life Benefit Plan Form, during the initial 30-day enrollment period.

WHEN BASIC LIFE COVERAGE BECOMES EFFECTIVE

Coverage begins one month and one day after the Employee's hire date. An Employee who is not Actively at Work on such date will not become covered until the date the Employee is again Actively at Work.

Central Payroll Employees. When approved by the Plan Administrator, the effective date of any approved changes during the Plan Year is the 1st or 15th of a month determined by the date during the payroll cycle in which most closely follows the 1st or the 15th of a month.

Board of Regents Employees. When approved by the Plan Administrator, the effective date of the approved changes made during the Plan Year is the 1st of a month.

In all cases, the actual coverage effective date will be contingent on receipt of all appropriate forms and required contributions.

COST OF BASIC LIFE COVERAGE

The cost of Basic Life Coverage is paid entirely by the Employer.

WHEN BASIC LIFE COVERAGE ENDS

The Employee's benefit under Basic Life Coverage ends when the:

(a) Employee's employment ends;

(b) Employee ceases to be a member of the class or classes eligible for such coverage;

(c) Employee dies; or

(d) Plan terminates.

The effective date when coverage terminates is the 1st or 15th of the month following the last payroll date in which contributions were paid.

BENEFICIARY – BASIC LIFE COVERAGE FOR EMPLOYEES

A beneficiary is the person or persons designated by the Employee in writing or online, on a form prescribed by the Plan. An Employee may name more than one primary beneficiary to receive benefits in the amount or amounts specified. An Employee should also name a contingent beneficiary or beneficiaries who are entitled to benefits in the event there are no surviving primary beneficiary(ies).

A beneficiary designation change must be made by completing an online form or a written notice (on a Group Life Benefit Plan Form) with the Plan Administrator. Once filed, the change is effective as of the date the new designation was signed, even though the Employee may not be living when the entry is made in the Plan's benefit records.

The consent of a beneficiary is not needed to name a beneficiary or to make a beneficiary change.

NOTE: Benefits will not be paid to a primary beneficiary or contingent beneficiary who commits murder or manslaughter of the covered individual. Instead, these benefits will be paid to the other primary beneficiary(ies) or contingent beneficiary(ies). If there are no other primary beneficiary(ies) or contingent beneficiary(ies), benefits will be paid to the estate of the deceased. In no event will the person committing murder or manslaughter receive any of the benefits through the estate.

FACILITY OF PAYMENT – BASIC LIFE COVERAGE FOR EMPLOYEES

If the beneficiary is a minor, or for any other reason is not capable of giving a valid release for any payment due, the Plan Administrator may make the payment to the beneficiary's Legal Guardian.

The Plan Administrator will pay the Employee's estate in the event that no beneficiary designation is in effect or where no designated beneficiary is living at the time of the Employee's death. In the event there is a question or dispute regarding the proper recipient of the proceeds, the Plan Administrator may make payment directly to the Employee's estate which shall hold such proceeds until such matter is resolved. The liability of the Plan Administrator shall be fully discharged to the extent of payment made under this provision.

ELIGIBILITY AND APPLYING FOR COVERAGE – SUPPLEMENTAL LIFE COVERAGE FOR EMPLOYEES

Some terms used in General Provisions are defined below. Others may be explained in the "Words and Phrases" section.

WHO MAY BECOME COVERED - SUPPLEMENTAL LIFE COVERAGE FOR EMPLOYEES

A Benefit Eligible Employee is automatically eligible for Supplemental Life Coverage. A Benefit Eligible Employee is considered eligible on the latest of:

(a) completion of any applicable Waiting Period;

(b) the date the Employee is included in the Eligible Class; or

(c) the Effective Date.

AMOUNT OF SUPPLEMENTAL LIFE COVERAGE

The Employee may choose Supplemental Life Coverage equal to two, three, four, or five times annual earnings (rounded to the next highest multiple of $1,000), but in no event shall the amount of coverage exceed $400,000. Annual Earnings does not include any other compensation such as longevity pay, fringe benefits, bonuses, overtime pay, or summer school compensation.

APPLICATION FOR SUPPLEMENTAL LIFE COVERAGE

New Hire:

During the initial 30-day enrollment period, an Employee must complete the online Group Life Benefit Plan Form to receive Supplemental Life Coverage. Failure to complete the online Group Life Benefit Plan Form will result in no Supplemental Life Coverage. However, the Employee may apply during the Plan Year by completing a printed Group Life Benefit Plan Form.

Active Employee:

After the initial 30-day enrollment period, an Employee must complete the online Group Life Benefit Plan Form along with the Evidence of Insurability Form to apply for Supplemental Life Coverage.

If evidence of insurability is required, the Employee will be notified of the determination regarding approval or denial.

WHEN SUPPLEMENTAL LIFE COVERAGE BECOMES EFFECTIVE

Such election will be effective on the latest of:

(a) completion of any applicable Waiting Period;

(b) the date the Employee is included in the Eligible Class; or

(c) the Effective Date.

The date the Employee becomes covered under the Supplemental Life Coverage will be determined as follows:

If an Employee elects coverage as a new hire and contributions for coverage are withheld from the Employee's first payroll cycle, coverage becomes effective one month and one day after employment begins. Otherwise, coverage begins on the 1st or 15th of the month following the payroll date in which contributions are received.

Central Payroll Employees. When approved the effective date of any changes during the Plan Year is the 1st or 15th of a month.

Board of Regents Employees. When approved the effective date of any changes during the Plan Year is the 1st of a month.

In all cases, the actual coverage effective date will be contingent on receipt of all required and completed forms and required contributions.

Increases in Supplemental Life Coverage because of a pay increase or age change will be reflected on the 1st or 15th of the month following the pay increase.

In any event, an Employee must be Actively at Work on the date the increase or election of Supplemental Life Coverage would otherwise become effective. An Employee who is not Actively at Work on such date will not become covered until the date the eligible employee is Actively at Work.

COST OF SUPPLEMENTAL LIFE COVERAGE

Active Employees pay the entire cost of Supplemental Life Coverage through after-tax payroll deductions. These after-tax contributions are deducted from payroll on a semi-monthly or monthly basis. Contribution amounts are calculated per $1,000 of coverage. Age-graded bands determine the appropriate contribution rate to use in this calculation. To view current rates, click here.

NOTE: The Plan Administrator may change the contribution rate assigned to each age-graded band at any time it deems necessary, with a minimum of 30 days notice to Employees before the change is effective.

During the Plan Year, contribution amounts will increase if the Employee's Annual Earnings increase or if an Employee moves into a new age-graded band. Increases because of an earnings increase will be effective on the 1st or 15th of the month following the pay increase. Increases because of a change in age will be effective on the first payroll date in the month of the age increase.

RIGHT TO REQUIRE EVIDENCE OF INSURABILITY – SUPPLEMENTAL LIFE COVERAGE FOR EMPLOYEES

After the initial enrollment period, Employees may apply for Supplemental Life Coverage or increase Supplemental Life Coverage levels by making application on a Group Life Benefit Plan Form available from your Personnel Office or online at http://benefits.sd.gov.

In the following situations, the Plan Administrator may require evidence of insurability which satisfies that the Employee is eligible for Supplemental Life Coverage:

(a) If the Employee applies for Supplemental Life Coverage more than 30 days after becoming an eligible Employee;

(b) If the Employee wants to increase coverage more than 30 days after becoming eligible for benefits; or

(c) To reinstate coverage for the Employee if coverage ended because the Employee did not make a required contribution.

WHEN SUPPLEMENTAL LIFE COVERAGE ENDS OR CANCELLATION OF SUPPLEMENTAL LIFE COVERAGE

The Employee's benefit ends under Supplemental Life Coverage when the:

(b) Employee's employment ends;

(c) Employee ceases to be a member of the class or classes eligible for such coverage;

(d) Employee dies;

(e) Employee stops making contributions for such coverage; or

(f) Plan terminates.

The effective date when coverage terminates is the 1st or 15th of the month following the last payroll date in which contributions were paid.

Coverage may be reduced or cancelled at any time by completing the required Group Life Benefit Plan Form available from your Human Resource, Personnel Office or online at http://benefits.sd.gov. The reduction or cancellation becomes effective the 1st or 15th of the month following the payroll date reflecting the change of contribution.

BENEFICIARY – SUPPLEMENTAL LIFE COVERAGE FOR EMPLOYEES

A beneficiary is the person or persons designated by the Employee in writing or online, on a form prescribed by the Plan. An Employee may name more than one primary beneficiary to receive benefits in the amount or amounts specified. An Employee should also name a contingent beneficiary or beneficiaries who are entitled to benefits in the event there are no surviving primary beneficiary(ies).

A beneficiary designation change must be made by completing an online form or a written notice (on a Group Life Benefit Plan Form) with the Plan Administrator. Once filed, the change is effective as of the date the new designation was signed, even though the Employee may not be living when the entry is made in the Plan's benefit records.

The consent of a beneficiary is not needed to name a beneficiary or to make a beneficiary change.

NOTE: Benefits will not be paid to a primary beneficiary or contingent beneficiary who commits murder or manslaughter of the covered individual. Instead, these benefits will be paid to the other primary beneficiary(ies) or contingent beneficiary(ies). If there are no other primary beneficiary(ies) or contingent beneficiary(ies), benefits will be paid to the estate of the deceased. In no event will the person committing murder or manslaughter receive any of the benefits through the estate.

FACILITY OF PAYMENT – SUPPLEMENTAL LIFE COVERAGE FOR EMPLOYEES

If the beneficiary is a minor, or for any other reason is not capable of giving a valid release for any payment due, the Plan Administrator may make the payment to the beneficiary's Legal Guardian.

The Plan Administrator will pay the Employee's estate in the event that no beneficiary designation is in effect or that no designated beneficiary is living at the time of the Employee's death. In the event there is a question or dispute regarding the proper recipient of the proceeds, the Plan Administrator may make payment directly to the Employee's estate which shall hold such proceeds until such matter is resolved. The liability of the Plan Administrator shall be fully discharged to the extent of payment made under this provision.

BASIC LONG-TERM-CARE (LTC) BENEFIT

Active Employees who carry the State's Group Supplemental Life Coverage will automatically receive a Basic Long-Term-Care (LTC) benefit. Unum insures this benefit. The Basic benefit provides $1,500 per month if a member is unable to work due to the loss of two or more Activities of Daily Living (ADLs) and is confined to a nursing home. Partial benefits are provided if a member resides in an Assisted Living Center or receives professional help in the home. The maximum amount for this benefit is $36,000 which is equivalent to a 2-year duration with a $1,500 monthly benefit. Contact our local representative of Unum, Risty Benefits, Inc. directly at 605.338.1489 or Unum directly at 800.227.4165 to learn about the exceptions and exclusions that may apply.

Employees who have their Supplemental Life Coverage stopped or terminated will receive a Continuation of LTC Coverage Election Form. The employee can then elect to continue their LTC insurance directly through UnumProvident after the group coverage terminates. If the employee wishes to elect continuation of coverage, a completed form must be sent directly to UnumProvident. The member will then be responsible for the entire cost of the LTC coverage.

ELIGIBILITY AND APPLYING FOR COVERAGE – OPTIONAL LIFE COVERAGE FOR DEPENDENTS

Some terms used in General Provisions are defined below. Others may be explained in the "Words and Phrases" section.

WHO MAY BECOME COVERED- OPTIONAL DEPENDENT LIFE COVERAGE

An Employee may also insure those persons who qualify as eligible Dependents. Dependent Life Coverage is available at the time the Employee becomes eligible for Basic Life Coverage provided Supplemental Life Coverage is elected.

AMOUNT OF COVERAGE

Employees who are covered under Supplemental Life Coverage may elect $10,000 Dependent Life Coverage.

APPLICATION FOR OPTIONAL COVERAGE

Employees must be enrolled in the Supplemental Life Coverage to enroll in Optional Life Coverage for Dependents.

New Hire:

During the initial 30-day enrollment period, an Employee must complete the online Group Life Benefit Plan Form or Group Life Form to receive Supplemental Life Coverage. Failure to complete the online Group Life Benefit Plan Form will result in no Supplemental Life Coverage. However, the Employee may apply during the Plan Year by completing a printed Group Life Benefit Plan Form or by going online.

Active Employee:

After the initial 30-day enrollment period, an Employee must complete the online Group Life Benefit Plan form to apply for Dependent Life Coverage or by going online.

Employees may cancel coverage at any time by completing the Group Life Benefit Plan Form available from a Human Resource Manager or online at http://benefits.sd.gov. The cancellation becomes effective the 1st or 15th of the month following the payroll date reflecting the change.

WHEN OPTIONAL DEPENDENT LIFE COVERAGE BECOMES EFFECTIVE

The effective date(s) of coverage for the Employee's Dependent(s) is determined as follows.

(a) Coverage begins one month and one day after the Employee's date of hire if the Dependent is enrolled and contributions are withheld from the Employee's first payroll cycle.

Otherwise, the coverage effective date for that person is the 1st or 15th of the month following the payroll date in which contributions are first withheld.

(b) If the Dependent is eligible for coverage without requiring evidence of insurability, coverage for that person becomes effective on the 1st or 15th of the month following the payroll date which

shows a deduction for Dependent Life Coverage. However, with respect to Dependent Life Coverage for a child under 14 days of age, no earlier than the date the child becomes 14 days old.

Central Payroll Employees. When approved by the Plan Administrator, the effective date of any changes during the Plan Year is the 1st or 15th of a month determined by the date during the payroll cycle in which most closely follows the 1st or the 15th of a month.

Board of Regents Employees. When approved by the Plan Administrator, the effective date of the changes made during the Plan Year is the 1st of a month.

In all cases, the actual coverage effective date will be contingent on receipt of all required completed forms and required contributions.

In any event, the Employee must be Actively at Work on the date Dependent Life Coverage would otherwise become effective. A Dependent of an Employee who is not Actively at Work on such date will not become covered until the date the Employee is again Actively at Work.

COST OF OPTIONAL DEPENDENT LIFE COVERAGE

The Employee pays the full cost of Dependent Life Coverage on an after-tax basis. These after-tax contributions are deducted from payroll on a semi-monthly or monthly basis. Contribution amounts are calculated per $1,000 of coverage. Age-graded bands determine the appropriate contribution rate to use in this calculation. To view current rates, click here.

WHEN OPTIONAL DEPENDENT LIFE COVERAGE ENDS OR CANCELLATION OF DEPENDENT LIFE COVERAGE

Dependent life coverage ends when:

(a) Loss of Dependent eligibility – see definition;

(b) Dependent dies;

(c) Employee's employment ends;

(d) Employee ceases to be a member of the class or classes eligible for such coverage;

(e) Employee dies;

(f) Employee stops making contributions for such coverage; or

(g) Plan terminates.

In the situations listed above, coverage will end on the 1st or 15th of the month following the last payroll date in which contributions were paid.

BENEFICIARY – OPTIONAL DEPENDENT LIFE COVERAGE

The Employee is the beneficiary of any Dependent Life Coverage. If the Employee and a covered Dependent pass away in a common accident, the Employee's spouse will receive any Dependent Life Coverage benefits. If both Employee and Employee's spouse die in a common accident, or the Employee is not married at the time of death, any Dependent Life Coverage benefit proceeds will be payable to the Employee's estate.

NOTE: Benefits will not be paid to a primary beneficiary or contingent beneficiary who commits murder or manslaughter of the covered individual. Instead, benefits will be paid to the other primary beneficiary(ies) or contingent beneficiary(ies). If there are no other primary beneficiary(ies) or contingent beneficiary(ies), benefits will be paid into the estate of the deceased. In no event will the person committing murder or manslaughter receive any of the benefits through the estate.

PAYMENT OF BENEFITS

LIFE COVERAGE FOR EMPLOYEES - BASIC AND SUPPLEMENTAL

The Plan Administrator will pay a benefit to the Employee's beneficiary(ies) upon proof of the Employee's death while covered under this Plan. This benefit is equal to the amount of coverage in force at the time of Employee's death, as determined from the Basic and Supplemental Life Coverage section of the Master Schedule.

The Employee's beneficiary(ies) are designated by the Employee according to the beneficiary provisions in the Basic Life Coverage and Supplemental Life Coverage Sections.

The death benefit will be paid in one lump sum to the beneficiary(ies).

Proof of Loss

Written proof of loss for which a claim is made must be furnished to the Plan Administrator within 180 days after the Employee's death, unless it was not reasonably possible to submit proof within that time limit. A certified death certificate is acceptable proof.

Claims Administrator's Right to Investigate Claims

The Plan Administrator has the right to investigate the claim, if necessary, and to contact any other organization or person to obtain additional information about the claim. The claim will be denied if misrepresentation, falsification, or omission of information is found.

Limitations

No benefits are payable under this coverage for any loss that occurs before coverage begins or after coverage ends or for any loss caused directly or indirectly by:

(a) Suicide while sane or insane, for a period of two (2) years from the date of such coverage; or

(b) Any injury, illness, or disability sustained on full-time active duty in the armed forces of declared war or undeclared war, including resistance to armed aggression;

Benefits will not be paid to a primary beneficiary or contingent beneficiary who commits murder or manslaughter of the covered individual. Instead, benefits will be paid to the other primary beneficiary(ies) or contingent beneficiary(ies). If there are no other primary beneficiary(ies) or contingent beneficiary(ies), benefits will be paid into the estate of the deceased. In no event will the person committing murder or manslaughter receive any of the benefits through the estate.

Termination of Life Benefits

If an Employee terminates full-time employment, Basic Life Coverage and Supplemental Life Coverage for the Employee ends on the 1st or 15th of the month following the last payroll date in which contributions were paid.

Continuation of Life Coverage Benefit

Employees whose Basic and Supplemental Life Coverage would normally end due to termination of employment, failure to return to work within 31 days after recovery from a disability, reduction of working hours below the level of a Benefit Eligible Employee, or otherwise ceasing to be an eligible employee, may continue their Group Life Coverage for a limited period at their own expense. Dependent Life Coverage cannot be continued.

Also, Dependents and/or beneficiary(ies) cannot request continuation of Employee Basic or Supplemental Life Coverage if the Employee dies before electing to continue life coverage.

Amount of Coverage

The maximum amount of Life Coverage that may be continued is the amount of Basic and Supplemental Life Coverage that was in force at the time of the qualifying event. The minimum amount that may be continued is the amount of Basic Life Coverage ($25,000) in force at the time of the qualifying event. The Employee may choose an amount between the minimum and maximum coverage in increments of $1,000.

Cost and Method of Payment

Continuation participants pay the entire cost of their Basic and Supplemental Life Coverages. After the initial billing, payments are made on a monthly basis and are deducted from a bank account.

Waiver of Contribution Benefits -Total Disability

If an Employee is totally disabled, the Basic and Supplemental Life Coverage may continue during the period of disability. In addition, the Supplemental Life Coverage contributions may be waived as indicated below, up to age 65.

As used in this provision, totally disabled means the Employee is permanently and continuously disabled by injury or disease to the extent the Employee cannot work for pay or profit and is not able to take part in any business or occupation.

The Employee must submit satisfactory proof of disability within one year of Total Disability. Proof of a disability shall consist of written certification from the Social Security Administration or by having your physician complete the Application for Waiver of Life Premium form, available online at http://benefits.sd.gov. The Application for Waiver of Life Premium form must be completed and signed by your treating physician in order for the Plan Administrator to consider disability waiver of premium. If approved, contributions will be waived once the Employee is no longer listed as an active Employee on the payroll system.

Waiving of contributions will continue for one year while the Employee remains totally disabled . Thereafter, contributions will be waived for successive one year periods while the Employee remains

totally disabled, if satisfactory proof is received by the Plan Administrator during the last three months of the preceding period that the total disability continues.

The Plan Administrator will have the right to require proof from time to time of the continuance of total disability during the first two years after receipt of the initial proof of such disability. Thereafter, proof will be required not more than once a year. As part of any proof, the participant may be required to be examined at the Plan Administrator's expense by a medical examiner of its choice.

The amount of coverage in which contributions are waived is the amount in force on the date the total disability began. The amount of the Employee's coverage in which contributions are waived will be reduced at the times and to the extent it would have been reduced had the Employee remained covered, but not disabled. Dependent Life Coverage is not provided under this waiver provision.

If the Employee dies while coverage is being continued under this provision, the amount of coverage in force under the Plan at the time of death will be paid to the beneficiary(ies).

If the Employee does not return to active work in a class eligible for life coverage under the Plan within 31 days after benefits under this provision ends, the Employee may exercise a continuation privilege, as described in "Continuation of Life Benefit." The Employee may do this as though termination of employment had occurred on the date the employee's life benefits ended.The Employee can continue Basic and Supplemental Life Coverage from age 65 to age 70 by paying the appropriate contributions for coverage.

Length of Continuation Coverage

<u>This continuation of coverage is offered by the State of South Dakota and is not covered by Federal COBRA legislation.</u>

ENDING EMPLOYMENT:

If the Employee leaves employment, loses Benefit Eligible Employee status or retires, the Employee may continue Basic and Supplemental Life Coverage until the earliest of:

(a) 18 months from the date the Employee's full-time employment ends;

(b) 29 months from the date the Employee's full-time benefited employment ends, in the event of a disability designation by receiving a Disability Retirement benefit from South Dakota Retirement System (SDRS), or a disability designation by the Social Security Administration; or

(c) The last day of the month in which the Employee turns age 70.

RETIREE:

Employees who are receiving monthly retirement benefits as retirees from the State of South Dakota may continue coverage until the last day of the month in which they turn age 70. There is no conversion policy.

Benefits Payable During Continuation Period

If the Employee dies during the continuation period, the Plan Administrator will pay a death benefit to the Employee's beneficiary(ies) or estate:

(a) Upon receipt of due proof of the Employee's death (a death certificate) within 180 days after the Employee's death unless it was not reasonably possible to submit proof within that time limit; and

(b) Equal to the amount of Basic Life Coverage and Supplemental Life Coverage issued to the Employee during the continuation period.

Termination of Continuation Coverage

A continuation participant may voluntarily terminate coverage through written notice to the Plan Administrator. Coverage will also end if contribution payments are not paid in a timely manner.

LIFE COVERAGE FOR DEPENDENTS

The Plan Administrator will normally pay a benefit to the Employee upon receipt of due proof of the death of a Dependent while covered under this Plan. This benefit is $10,000 per covered Dependent.

Proof of Loss

Written proof of loss for which a claim is made must be furnished to the Plan Administrator within 180 days after the Dependent's death, unless it was not reasonably possible to submit proof within that time limit. A certified death certificate is acceptable proof.

Claims Administrator's Right to Investigate Claims

The Plan Administrator has the right to investigate the claim, if necessary, and to contact any other organization or person to obtain additional information about the claim. The claim will be denied if misrepresentation, falsification, or omission of information is found.

Limitations

No benefits are payable under this coverage for any loss that occurs before coverage begins or after coverage ends or for any loss caused directly or indirectly by:

(a) Suicide, while sane or insane, for a period of two (2) years from the date of coverage; or

(b) Any injury, illness, or disability sustained on full-time active duty in the armed forces of declared war or undeclared war, including resistance to armed aggression;

Benefits also will not be paid to a primary beneficiary or contingent beneficiary who commits murder or manslaughter of the covered individual. Instead, benefits will be paid to the other primary beneficiary(ies) or contingent beneficiary(ies). If there are no other primary beneficiary(ies) or contingent beneficiary(ies), benefits will be paid to the estate of the deceased. In no event will the person committing murder or manslaughter receive any of the benefits through the estate.

Termination of Dependent Life Benefits

If an Employee terminates full-time employment, Dependent Life Coverage will cease on the 1st or 15th of the month following the last payroll date in which contributions were paid.

Dependent Life Coverage will also end if the covered Dependent no longer meets eligibility requirements. In this situation, coverage for that person ends on the last day of the month in which the Dependent becomes ineligible.

Extension of Dependent Life Benefits

The Plan Administrator does not extend continuation of Life Benefits to Dependents.

ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE FOR EMPLOYEES

PROOF OF LOSS

Written proof of loss for which a claim is made, such as a death certificate or physician's statement, must be furnished to the Plan Administrator within 180 days after the date of loss, unless it is not reasonably possible to do so.

Proof of Loss for an Accidental Injury

Proof of loss for an accidental injury must include information regarding:

(a) When and how the loss occurred;

(b) The nature of the loss; and

(c) The extent of the loss.

Failure to furnish such proof within the applicable time limit will not result in denial or reduction of a claim if it is shown that:

(a) It was not reasonably possible to provide such proof within the time limit that applies; and

(b) Such proof was provided as soon as reasonably possible.

Benefit Payments

Upon receipt by the Plan Administrator of due written proof of loss, benefits under the policy are paid as follows:

(a) Benefits for loss of life under Accidental Death and Dismemberment Coverage are paid to the Employee's beneficiary(ies) or to one or more other persons under terms of the "Facility of Payment" provision. Any other benefit under that coverage is paid to the Employee.

(b) Benefits for accidental injury under Basic and Supplemental Life Coverage are also paid to the Employee.

(c) Benefits to which the Employee is entitled which remain unpaid at the Employee's death are paid to the Employee's beneficiary(ies), if a designated beneficiary(ies) survives the Employee. Otherwise, such benefits are paid under terms of the "Facility of Payment" provision.

Physical Exams and Autopsy

The Plan Administrator, at its own expense, may require the person whose injury or disease is the basis of a claim be examined by a physician chosen by the Plan Administrator. The Plan Administrator may require such 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.

Benefits

If the Employee suffers any loss shown below in the Schedule of Benefits due to an injury, the Plan Administrator may pay the benefit shown for that loss upon receipt of due written proof that the:

(a) Injury occurred while the Employee was covered under this Plan;

(b) Loss resulted directly and solely from the injury and independently of all other causes; and

(c) Loss occurred not more than 180 days after the injury.

Schedule of Benefits

See the Accidental Death and Dismemberment section of the Master Schedule for the Full Amount of such coverage that applies to an Employee.

(a) $12,500 - One-half the Full Amount of Accidental Death and Dismemberment Coverage that applies to the Employee will be paid for loss of:

- sight of one eye; or
- one foot; or
- one hand.

(b) $25,000 - The Full Amount of Accidental Death and Dismemberment Coverage that applies to the Employee will be paid for loss of:

- both hands; or
- both feet; or
- one hand and one foot; or
- sight of both eyes; or
- one foot and sight of one eye; or
- one hand and sight of one eye.

(c) The Full Amount of Accidental Death and Dismemberment Coverage, Basic Life Coverage, and two (2) times the Supplemental Life Coverage which applies to the Employee will be paid for loss of life.

The total benefit the Plan Administrator will pay for all losses suffered as a result of any one accident shall not exceed the Full Amount of Accidental Death and Dismemberment Coverage that applies to the Employee.

Loss of hands or feet means permanent loss by severance at or above the wrist or ankle joint. Loss of sight means total and irrecoverable loss of sight.

Limitations

No benefits are payable under this coverage for any loss that occurs before coverage begins or after coverage ends or for any loss caused directly or indirectly by:

(a) Disease, infirmity or their treatment;

(b) Bacterial infection, unless introduced through a visible wound caused by an accident;

(c) Suicide or attempted suicide while sane or insane;

(d) Intentional self-inflicted injury; or

(e) War or act of war, declared or undeclared.

Benefits also will not be paid to a primary beneficiary or contingent beneficiary who commits murder or manslaughter of the covered individual. Instead, benefits will be paid to the other primary beneficiary(ies) or contingent beneficiary(ies). If there are no other primary beneficiary(ies) or contingent beneficiary(ies), benefits will be paid to the estate of the deceased. In no event will the person committing murder or manslaughter receive any of the benefits through the estate.

Termination of Accidental Death and Dismemberment Benefits

The Employee's Accidental Death and Dismemberment Coverage ends when the:

(a) Employee's employment ends;

(b) Employee ceases to be a member of the class or classes eligible for such coverage;

(c) Employee dies;

(d) Employee stops making contributions for such coverage; or

(e) Plan terminates.

The effective date when coverage terminates is the 1st or the 15th of the month following the last payroll date in which contributions were paid.

Extension of Accidental Death and Dismemberment Benefits

The Plan Administrator does not extend continuation benefits for Accidental Death and Dismemberment Coverage.

ACCIDENTAL DEATH AND DISMEMBERMENT COVERAGE FOR DEPENDENTS

Proof of Loss

Written proof of loss for which a claim is made, such as a death certificate or physician's statement, must be furnished to the Plan Administrator within 180 days after the date of loss, unless it is not reasonably possible to do so.

Proof of Loss for an Accidental Injury

Proof of loss for an accidental injury must include information regarding:

(a) When and how the loss occurred;

(b) The nature of the loss; and

(c) The extent of the loss.

Failure to furnish such proof within the applicable time limit will not result in denial or reduction of a claim if it is shown that:

(a) It was not reasonably possible to provide such proof within the time limit that applies; and

(b) Such proof was provided as soon as reasonably possible.

BENEFIT PAYMENTS

Upon receipt by the Plan Administrator of due written proof of loss, benefits under the policy are paid as follows:

(a) Benefits for loss of life under Accidental Death and Dismemberment Coverage are paid to the Employee's beneficiary(ies) or to one or more other persons under terms of the "Facility of Payment" provision. Any other benefit under that coverage is paid to the Employee.

(b) Benefits to which the Employee is entitled which remain unpaid at the Employee's death are paid to the Employee's beneficiary(ies), if a designated beneficiary(ies) survives the Employee. Otherwise, such benefits are paid under terms of the "Facility of Payment" provision.

Physical Exams and Autopsy

The Plan Administrator, at its own expense, may require the person whose injury or disease is the basis of a claim be examined by a physician chosen by the Plan Administrator. The Plan Administrator may require such 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.

Benefits

Benefits under this coverage are provided subject to proof of loss requirements described on page 8.1.

If a Dependent suffers any loss shown in the Schedule of Benefits due to an injury, the Plan Administrator will pay the benefit shown for that loss upon receipt of due written proof that the:

(a) Injury occurred while the dependent was covered under this Plan;

(b) Loss resulted directly and solely from the injury and independently of all other causes; and

(c) Loss occurred not more than 180 days after the injury.

Schedule of Benefits

See the Accidental Death and Dismemberment section of the Master Schedule for the Full Amount of such coverage that applies to a Dependent.

(a) $5,000 - One-half the Full Amount of Accidental Death and Dismemberment Coverage that applies to such Dependent will be paid for loss of:

- sight of one eye; or
- one foot; or
- one hand.

(b) $10,000 - The Full Amount of Accidental Death and Dismemberment Coverage that applies to the Dependent will be paid for loss of:

- both hands; or
- both feet; or
- one hand and one foot; or
- sight of both eyes; or
- one foot and sight of one eye; or

- one hand and sight of one eye.

(c) The Full Amount of Accidental Death and Dismemberment Coverage and the Dependent Coverage which applies to the Dependent will be paid for loss of life.

The total benefit the Plan Administrator will pay for all losses a Dependent suffers as a result of any one accident shall not exceed the Full Amount of Accidental Death and Dismemberment Coverage that applies to that Dependent.

Loss of hands or feet means permanent loss by severance at or above the wrist or ankle joint. Loss of sight means total and irrecoverable loss of sight.

See the Accidental Death and Dismemberment section of the Master Schedule for the Full Amount of such coverage that applies to such Dependent.

Limitations

No benefits are payable under this coverage for any loss that occurs before coverage begins or after coverage ends or for any loss caused directly or indirectly by:

(a) Disease, infirmity or treatment of same;

(b) Bacterial infection, unless introduced through a visible wound caused by an accident;

(c) Suicide or attempted suicide while sane or insane;

(d) Intentional self-inflicted injury; or

(e) War or act of war, declared or undeclared.

Benefits will not be paid to a primary beneficiary or contingent beneficiary who commits murder or manslaughter of the covered individual. Instead, benefits will be paid to the other primary beneficiary(ies) or contingent beneficiary(ies). If there are no other primary beneficiary(ies) or contingent beneficiary(ies), benefits will be paid to the estate of the deceased. In no event will the person committing murder or manslaughter receive any of the benefits through the estate.

Termination of Accidental Death and Dismemberment Benefits

A Dependent's Accidental Death and Dismemberment Optional Coverage ends when the:

(a) Loss of Dependent eligibility – see definition;

(b) Dependent dies;

(c) Employee's employment ends;

(d) Employee ceases to be a member of the class or classes eligible for such coverage;

(e) Employee dies;

(f) Employee stops making contributions for such coverage; or

(g) Plan terminates.

The effective date when coverage terminates is the 1st or 15th of the month following the last payroll date in which contributions were paid.

Extension of Accidental Death and Dismemberment Benefits

The Plan Administrator does not extend continuation benefits for Accidental Death and Dismemberment Coverage.

PLAN OPERATIONS

PLAN ADMINISTRATION

The Bureau of Personnel is the State agency responsible for designing and administering the Plan, including the administration and payment of claims. The Plan Administrator reserves the right to change the Plan design, modify coverages, and change contributions or funding mechanisms at any time it deems necessary, with or without notice. The Plan Administrator or other fiduciary designated by the Plan Sponsor shall have final authority to make a determination with respect to such issues or such provisions, unless such determination is found to be arbitrary and capricious by a court of appropriate jurisdiction. The information contained in this document and its interpretation by the Plan Administrator's designee supersedes all verbal representations of the Plan provisions.

RIGHT TO RELEASE AND OBTAIN NECESSARY INFORMATION

The Plan Administrator 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:

(a) Determine if a Plan provision applies; and

(b) Implement its terms or the terms of any provision of similar purpose of any other Plan.

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

FACILITY OF PAYMENT

If the payments which should have been made by this Plan under the terms of this provision are made under other Plans, the Plan Administrator may, at its discretion, pay to any person making such payment the amount it determines satisfies the intent of this provision. To the extent of the amount of those payments, the Plan Administrator shall be discharged from liability under this Plan.

RIGHT TO RECOVERY

If the Plan Administrator makes payments with respect to Group Term Life Coverage 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.

PLAN MODIFICATION AND AMENDMENT

The State of South Dakota fully intends to continue the Plan or a similar Plan indefinitely. However, the Plan may be modified and amended at any time by the State of South Dakota or the Bureau of Personnel upon its due approval of such modification or amendment. The modification or amendment shall be effective on the date of approval or on such date as the State of South Dakota may determine in connection therewith. Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan.

PLAN TERMINATION

The State of South Dakota or the Bureau of Personnel may terminate the Plan at any time as of the date it authorizes. In the event of such termination, the State of South Dakota shall have no obligation under the Plan beyond paying the difference between:

(a) The claims incurred (even though later filed) and expenses of the Plan due up to the date of termination plus extended benefits, if any, provided under the Plan; and

(b) The funds available to pay such claims and expenses and extended benefits.

Such claims and expenses shall be paid from the funds in the Plan. No benefits will be paid for expenses incurred after the date the Plan ends.

The Bureau of Personnel has the final and binding authority to determine claims and direct the payment thereof. The Bureau of Personnel shall incur no liability for failure to make payment of any claim or to make ratable distribution on any claim without regard to the reasons therefore. The Bureau of Personnel shall have the right to employ third party administrators (TPA) under the Plan to aid it in the discharge of its duties hereunder.

SUBROGATION FOR LIFE BENEFITS

Occasionally, benefits are paid under the life coverage of the Plan for benefits paid as a result of the employee caused by the actions of a third party. If this happens, the Plan is subrogated, unless otherwise prohibited by law, to the rights of recovery that the Employee's beneficiary(ies) may have against any person or organization who may acknowledge liability or be found liable by a court of competent jurisdiction for the death of the member Employee.

The beneficiary(ies) will be required to reimburse the Plan out of any monies the beneficiary(ies) receives from any other person or organization as a result of judgment, settlement, or otherwise. The beneficiary(ies) will not be required to reimburse the Plan more than the amount the beneficiary(ies) recover for the death of the member.

Subrogation rights apply only to the extent that benefits are paid under the life coverage of the Plan. Any fees and costs associated with the recovery shall be borne by the Plan Administrator.

The State of South Dakota also reserves the right to pursue recovery from the third party at its discretion should the beneficiary(ies) decide not to attempt recovery. The beneficiary(ies) agree to cooperate with the Plan in seeking such a recovery as a condition of benefit they receive.

CLAIMS REVIEW PROCEDURE

NOTICE OF DENIAL OF CLAIM

The Director of Employee Benefits shall provide written notice to an eligible Employee or beneficiary whose claim for benefits is denied. The notice shall include the specific reason or reasons for denial, including reference to the Plan provision upon which denial is based, and a description of additional material or information necessary to complete the claim, including an explanation of the claims review procedure.

APPEAL FROM DENIAL OF CLAIM

An eligible Employee or beneficiary whose claim for benefits under Chapters 55:03:02 through 55:03:05 is denied may appeal to the Director of Employee Benefits within 30 days after receipt of the notice of denial. The Director of Employee Benefits shall investigate and make a decision within 30 days after receipt of the complaint. The eligible Employee or beneficiary may appeal the decision of the Director of Employee Benefits to the Commissioner of the Bureau of Personnel within 30 days after receipt of the decision.

APPEAL PROCEDURE

An eligible Employee or beneficiary who desires to appeal the decision of the Director of Employee Benefits regarding the denial of the claim shall submit the claim and the remedy sought in writing within 30 days to the Commissioner of the Bureau of Personnel. The Commissioner may request the Office of Hearing Examiners to hold an administrative hearing on the denied claim.

DECISION OF COMMISSIONER APPEALABLE

The Commissioner’s decision on the review of a denied claim shall be made within 60 days after the Commissioner receives the proposed decision from the Office of Hearing Examiners for review. The final decision of the Commissioner of the Bureau of Personnel may be appealed to the circuit court in accordance with SDCL 1-26.

LEGAL ACTION

No legal action or suit to recover on the Policy may be started before 60 days after written proof of loss has been furnished. Further, no such action or suit may be brought more than six years after the time such proof must be furnished. But, if either time limit is less than permitted by state law where the Employee or covered dependent resides when the loss occurs, that limit is extended to agree with the smallest limit the law of that state allows.

FAILURE TO COMPLY WITH TIME LIMITS

Failure by an eligible Employee or beneficiary whose claim has been denied to comply with time limits in the State of South Dakota administration rules constitutes a withdrawal of the claim. Failure of the Director of Employee Benefits or the Commissioner to comply with the time limits allows the claimant to initiate the next successive step of the procedure. A party may agree to a time extension requested in writing by the other party.

DELIVERY REQUIREMENTS FOR WRITTEN NOTICE

A written notice shall be delivered personally or mailed. The notice is effective on the date of receipt.

MISCELLANEOUS

ASSIGNMENT

No rights or benefits under the Policy may be assigned without prior written consent of the Plan Administrator.

GOVERNING LAW

This Plan shall be construed in accordance with the laws of the State of South Dakota except where such laws are superseded by the Internal Revenue Code of 1986 ("Code"), in which case the Code shall control.

CONSTRUCTION OF PLAN DOCUMENT

Any headings or subheadings in this Plan are inserted for convenience of reference only and in the event of any conflict, the text of this document, rather than such headings or subheadings, shall control.

SEVERABILITY CLAUSE

In the case any provision of this Plan shall be held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of this Plan and this Plan shall be construed and enforced as if such illegal or invalid provisions had never been inserted herein.

PLAN IN EFFECT AT TERMINATION OF EMPLOYMENT CONTROLS

Unless expressly indicated otherwise, no provision of this Plan shall apply to any Employee who terminated employment prior to the effective date of such provision. In addition, unless expressly indicated otherwise, any amendment to this Plan shall not apply to any Employee who terminates employment prior to the effective date of such amendment.

NON-GENDER CLAUSE

Any words used in the masculine shall be read and construed in the feminine where they would so apply. Words in the singular shall be read and construed as though in the plural in all cases where they would so apply.