Large Employer Operational Guide

SANFORD HEALTH PLAN

TABLE OF CONTENTS

Contact Information

Customer service representatives are available from 8 a.m. to 5 p.m. CST Monday through Friday. A confidential voicemail is available after hours and during the weekend. Calls are returned within one business day. All phone calls and electronic contact (i.e., email) are logged and recorded.

Department	Services Provided	Contact Information
Sales and Retention (Account Executive and Account Management Team)		(605) 328-7000 sales@sanfordhealth.org
Billing and Enrollment	Additions, changes, termination in coverage (status of processing), premium invoice or payment inquiries	(605) 312-2725 SHPbillingandenrollment@sanfordhealth.org
Customer service	Claim inquiries, coordination of benefits, order ID cards, benefit questions, complaints/appeals	(800) 752-5863 memberservices@sanfordhealth.org
Care Management	Medical and behavioral health case management and social work services	(888) 315-0884
Utilization management	Prior authorization, complex case management, referrals, medical necessity determinations, transplant services, healthy pregnancy program or disease management programs	(800) 805-7938
Pharmacy	Drug formulary or prescription questions	(855) 305-5062
Language line	Help for non-English speaking members	(800) 892-0675
My Sanford Nurse	Health questions or information on appropriate level of care, 24-hours, 7-days-a-week	(877) 473-1215

Holiday Closings: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day

Vendor	Services	Contact Information
HealthEquity	FSA, HSA, HRA, or POP Accounts	(866) 382-3510 employerservices@healthequity.com
WEX Health	COBRA administration	(877) 765-8810 COBRAemployerservices@wexinc.com

ENROLLMENT

Sanford Health Plan offers two methods of electronic enrollment:

- **Online portal:** *my*Enrollment offers a secure, easy-to-use enrollment portal that supports health insurance enrollment as well as year-round enrollment transactions. If you already have an enrollment portal, you can use this site to review member eligibility or order replacement ID cards. Get access by visiting **sanfordhealthplan.com/myenrollment**.
- **834 EDI:** Sanford Health Plan accepts ANSI X12N 834 benefit and enrollment maintenance transactions from an outside vendor when submitted in compliance with our 834 companion guide (available online and by request). Contact your account manager for this option.

It is your responsibility to notify your Account Manager of changes to your HR team for access to myEnrollment.

Enrollment guidelines

IMPORTANT – New enrollments, terminations, and other types of enrollment changes must be submitted to Sanford Health Plan within 31 days of the event.

New enrollments

New enrollments will occur from the following events:

- New hires electing coverage
- Existing employees electing coverage due to a qualified life event (see Qualified Life Events section on the following page)
- Existing employees electing coverage during annual open enrollment period

The employer is responsible for giving the employee a new hire booklet. This ensures that the new employee has all the information necessary to enroll in a medical insurance plan with Sanford Health Plan.

- If the employee is electing coverage, an enrollment application (or other form of electronic enrollment) must be completed for your records. Sanford Health Plan does not need a copy of the application.
- Once the enrollment application (or other form of electronic enrollment) is completed by the employee, the employer must notify Sanford Health Plan within 31 days of the enrollment event via electronic enrollment.
- Sanford Health Plan will process the enrollment within three to five business days of receipt.
- ID cards for the employee and any enrolled dependents will be mailed to the employee's home address.

Qualified Life Events (QLE)

Once enrolled, a member cannot change his or her health insurance election unless they have a qualifying event. Sanford Health Plan needs to be notified within 31 days of the qualified life event.

If a member has a qualifying event, the change made to the plan must be consistent with and appropriate for the new circumstances. See examples below*:

Qualified Life Event	Effective/Term date of change
Birth/adoption of a child or placement for adoption	Effective date is date of birth or adoption. *Child is added on the date of birth or adoption and any other family members added are effective the 1st of the following month.
Spouse loses group coverage	Effective on first of month that coincides with or following the qualifying event.
A dependent child attains the limiting age	Coverage is terminated the end of the month the dependent turns 26.
Change of marital status – marriage	Effective on first of month that coincides with or following the qualifying event.
Change of marital status – divorce	*Terminating spouse/dependent(s) on the last day of the month that coincides with or following the qualifying event. *Enroll employee and/or add dependent(s) on the first of the month that coincides with or following the qualifying event.
Loss of eligibility (i.e. FT to PT, termination, unpaid LOA...)	Terminations on the last day of the month that coincides with or following the qualifying event.
New employee/employee has change in status resulting in gain of eligibility in employer plan(s) (i.e. PT to FT, returning from unpaid LOA...)	Effective on first of month that coincides with or following the qualifying event.
Death of subscriber	1. Termination date is equal to date of death if single policy. 2. Termination date is equal to end of month for family members covered under the plan.
Death of spouse	Termination date is equal to date of death.
Medical child support order	Effective date according to the court order/state regulations.

**This is only a summary; please refer to plan documents for full details.*
NOTE: Members enrolled in a TRUE or PLUS product that move outside the service area will automatically be moved to the equivalent Signature Series (Broad Network) Plan

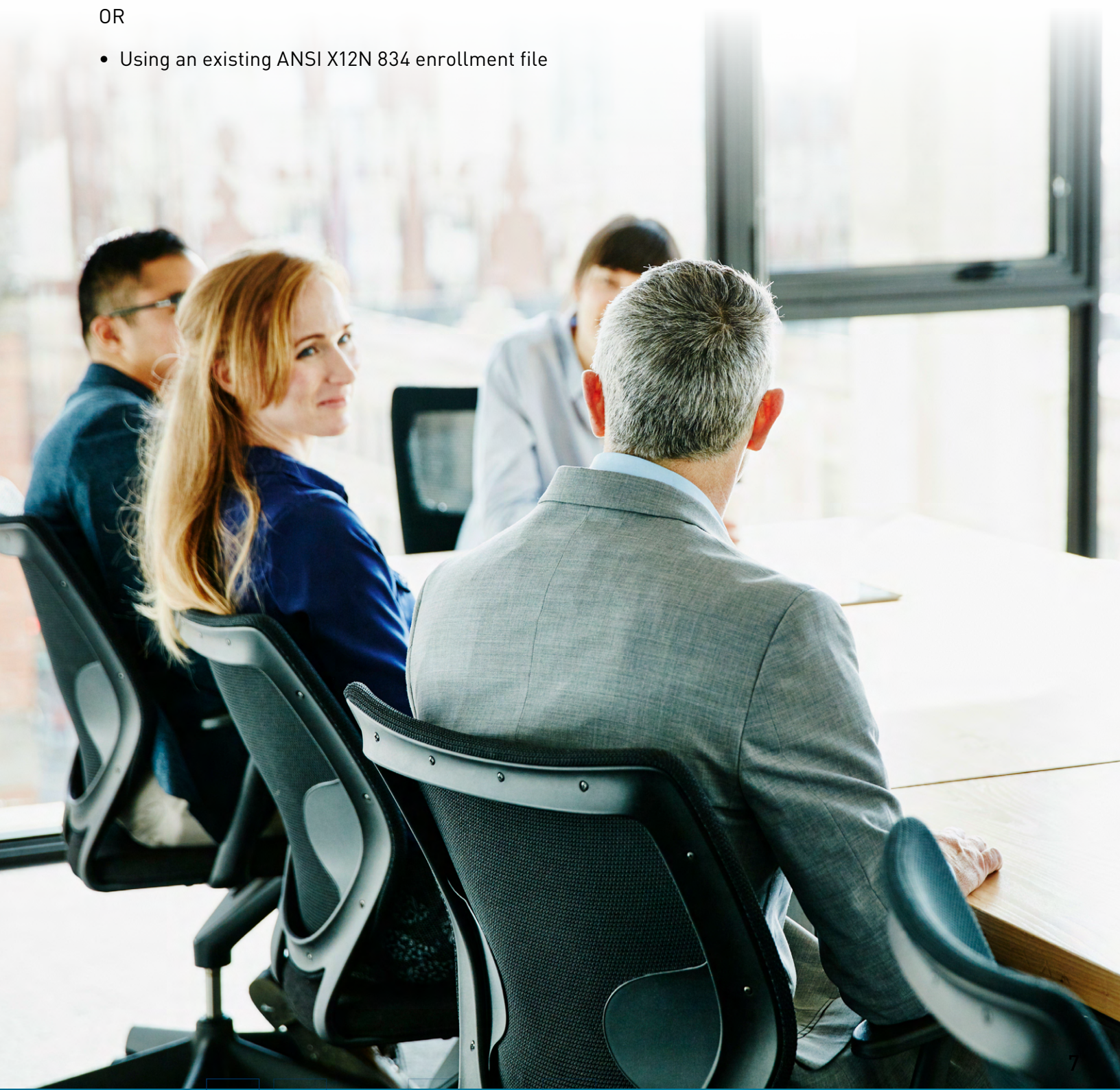
Enrollment changes/terminations

Enrollment changes (including name or address changes, involuntary terminations or loss of eligibility, etc.) must be received at Sanford Health Plan within 31 days of the event using:

- *my*Enrollment: enter all enrollment transactions through our online secure portal at **sanfordhealthplan.com/myenrollment**

OR

- Using an existing ANSI X12N 834 enrollment file



Finding the Provider Directory

For current Sanford Health Plan Members:

1. Visit sanfordhealthplan.com
2. Find a Doctor
3. Enter Last Name & Member ID Number
4. Run the directory based on your needs to get immediate results.

For new Sanford Health Plan Members:

1. Visit sanfordhealthplan.com
2. Find a Doctor
3. I'M A GUEST
4. Under the "THROUGH MY EMPLOYER" choose the desired network option

Broad Network – Signature Series

Sanford Health Plan's Signature Series broad network expands beyond the Sanford Health system for access to providers and facilities within the **Sanford Health Plan Service Area**. To receive in-network benefits, see providers in this directory. Prior authorization for certain services is still required, regardless of where you receive care. A national network is available to those members living or residing outside the **Sanford Health Plan Service Area**. Employees living outside the Service Area will automatically be provided access to the national network. If the employee lives in the Service Area and a spouse or dependent lives outside of the **Sanford Health Plan Service Area** complete an Out-of-Area Form to request access to the nationwide network for the spouse/dependent(s). If access is approved, nationwide network providers and facilities will process at the in-network benefit level. To view the nationwide network of providers, click here.

Tiered Network – PLUS

Sanford Health Plan's PLUS plans offer a tiered network which is grouped into two levels. Member cost share (copayments, deductibles, and coinsurance) is based on the tier of the provider from whom they receive care.

Tier 1 Preferred (which has the lowest member cost-share) includes our large care system of Sanford Health providers and facilities. Prior Authorization for certain services is still required.

Tier 2 Affiliated (which has a higher member cost-share) includes a broad network that expands beyond the Sanford Health system and includes providers and facilities within the Sanford Health Plan service area. To receive in-network benefits, see providers in this directory. Prior authorization for certain services is still required, regardless of where you receive care. If a spouse or dependent lives outside of the **Sanford Health Plan Service Area** complete an Out-of-Area Form to request access to the nationwide network at Tier 2. If access is approved, nationwide network providers and facilities will process at the in-network Tier 2 benefit level. To view the nationwide network of providers, **click here**.

Focused Network – TRUE

Our focused network consists of over 2,200 providers, including access to our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota and Iowa. You can choose to see any licensed Sanford Health provider for covered services without a referral for in-network coverage. This plan does not have out-of-network coverage, except for urgent and emergent situations.

Sanford Health Plan Service Area

SOUTH DAKOTA: all counties
NORTH DAKOA: all counties
MINNESOTA: Becker, Beltrami, Big Stone, Blue Earth, Brown, Chippewa, Clay, Clearwater, Cottonwood, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Kittson, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Murray, Nicollet, Nobles, Norman, Otter Tail, Pennington, Pipestone, Polk, Pope, Red Lake, Redwood, Renville, Rock, Roseau, Sibley, Stearns, Stevens, Swift, Traverse, Wilkin, Watonwan and Yellow Medicine counties
IOWA: Clay, Dickinson, Emmet, Ida, Lyon, O'Brien, Osceola, Plymouth, Sioux, and Woodbury counties

Additional Information

Urgent/Emergent

Members who need services, which are considered urgent or emergent, can seek care at any provider regardless of the provider network selected.

Out-of-Network Referrals

Members with non-emergency services that are referred to out-of-network providers will need prior approval* **BEFORE** they receive care. **Mayo Clinic** is considered out-of-network without prior approval by Sanford Health Plan. Some plans do not offer out-of-network coverage, so members are encouraged to check their insurance information (i.e. SBC) before receiving services outside the network without prior approval.

*To request prior approval the member's primary care provider will need to submit a request to receive care at an out-of-network provider through their Sanford Health Plan provider portal as a "SHP 2nd Opinion OON" or "SHP Network Exception" referral with medical justification. The request is reviewed for appropriate medical necessity or continuity of care. If approved, the service will process at in-network benefit level.

Dependent(s) permanently residing outside of Sanford Service Area

- Employees who cover spouses and/or dependents that **permanently** reside out of the TRUE or PLUS service area are **NOT** eligible for the TRUE or PLUS plan (i.e. court ordered spousal or dependent coverage).

College Students Living outside the Sanford Service Area

- **Tiered- PLUS:** Eligible employees who cover college students who attend school out of the Sanford PLUS service areas can elect the PLUS Plan; however, must acknowledge that most providers are at a Tier 2 benefit level.
- **Focused - TRUE:** Eligible employees who cover college students who attend school out of the Sanford TRUE service areas can elect the TRUE Plan; however, must acknowledge that coverage at college will only be for urgent/emergent care and all elective services must be received at an in-network provider in the TRUE service area.
    - If the college student requires non-emergency medical care while at college, the employee is encouraged to enroll in the Signature Series Plan.

Billing

Monthly premium invoices

Our standard billing practice allows coverage to begin the first of the month coinciding with or following the member's hire date or qualifying event and terminate on the last day of the month of employment. Sanford Health Plan does not pro-rate monthly billing. Monthly invoices are billed around the 20th of the prior month.

The invoice will include a list of your employees and their respective premium rate, based on their enrollment tier as appropriate. Invoices are due on the first of the month, as indicated on the invoice (i.e. Feb invoice will be sent on Jan 20th, due Feb 1st).

It is important to review your invoice monthly and report any discrepancies to your Account Executive or Account Manager. Sanford Health Plan only allows retro eligibility terms back 60 days.

The premium billing invoice for the month of January may occasionally be delayed due to the processing of open enrollment changes.

Claims Administration

How we pay claims

Benefits are configured based on the policy (**Certificate of Insurance**) and the Summary of Benefits and Coverage. Through the claims processing system, edits are configured to check for duplicate claims and to automatically link authorizations for procedures that require pre-certification. The claims system also utilizes an algorithm of edits that are configured to determine potential mismatches for diagnosis/procedure codes, age, specialty of provider, etc. Sanford Health Plan processes all medical claims internally and is not outsourced. Claims are repriced according to the provider contracts. Covered members using in-network providers will experience savings between the billed and allowed amounts per claim.

Auto adjudication

Sanford Health Plan processes approximately 94 percent of its claims electronically.

Explanation of Benefits (EOB)

Once claims are processed, Sanford Health Plan will communicate, either electronically or by paper, how the claim was processed. This is called an "Explanation of Benefit."

Members are able to elect electronic EOBs (instead of EOB mailing) through their secure member account at **sanfordhealthplan.com/memberlogin**.

B Claim Number: 1234567

D Provider/Vendor Name: DOCTOR NAME / FACILITY NAME/PLACE OF SERVICE

A Date of Service	Medical Service Details		Member Benefit		Amount Provider May Bill You				**L** Notes*
	C Type of Service	**E** Amount Billed	**F** Plan Discount	**G** Amount Paid by Plan	**H** Copay	**I** Deductible	**J** Coinsurance	**K** Amount Not Covered	
XX/XX/XXXX – XX/XX/XXXX	<type of service>	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	$XX.XX	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	<claim notes>
	Claim Total:	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	$XX.XX	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	
						Amount You May Owe		$XXXXX.XX	

L

*Notes
<claim notes>

A **Date of Service:** The date(s) you received care.

B **Claim Number:** Reference number Sanford Health Plan assigned to the submitted claim.

C **Type of Service:** Type of medical service received.

D **Provider/Vendor Name:** The provider or facility you received the service from.

E **Amount Billed:** Amount the provider or facility billed for the service.

F **Plan Discount:** Amount saved by using an in-network or participating provider (if applicable). Sanford Health Plan negotiates lower rates with these providers to help save money.

G **Amount Paid by Plan:** The maximum amount Sanford Health Plan allows a provider or facility to charge for the service(s).

H **Copay:** A set amount you pay for certain services, such as an office visit.

I **Deductible:** The amount of covered expense that must be paid by the member before Sanford Health Plan begins to pay. For example, if your deductible is $1,500, Sanford Health Plan won't pay for covered benefits until you've paid $1,500 for services that are subject to the deductible, which may include labs, imaging, procedures and hospitalizations.

J **Coinsurance:** The percentage of the payment that you are responsible for, once the deductible has been met. Coinsurance amount is calculated on the amount paid by the plan. For example, if you have a $100.00 service after you've met your deductible and your coinsurance is 80/20, the Plan will pay for 80 percent ($80) and you will pay 20 percent ($20).

K **Amount Not Covered:** Any amount that may not be covered by your benefit plan.

L **Notes:** Important information; these numbers and/or codes explain more about how claim was processed.

Coordination of Benefits

When a member is covered by two health insurance plans, we must determine which plan pays first and which plan pays second, referred to as "Coordination of Benefits (COB)". To ensure that our records are accurate and up to date, Sanford Health Plan may contact specific employees (with coverage on family members) to verify if other coverage exists. If your employees have received a COB Questionnaire, please encourage them to complete the form to prevent claim payment delays. Questions about COB can be sent to **healthplanCOB@sanfordhealth.org**.

Subrogation claims review – third party liability

It is important that we are good stewards of your health care premium dollars. Therefore, Sanford Health Plan partners with Optum to research certain claims that could be someone else's responsibility; this is called subrogation. (For example, motor vehicle insurance may be responsible for medical costs from a car accident.) When we receive claims with certain diagnosis codes, Optum contacts the member to determine if another party was responsible for the charges. If your employee asks about a call or has received a form in the mail from Optum, please have the employee respond to the questions appropriately, as their claims may be denied if they do not respond. Communication from Optum will be identified as "working on behalf of Sanford Health Plan". Members have three ways to provide the information to Optum: by phone, by mail, or online at **icc.optum.com**.

All information is strictly confidential and used only to determine payment liability.

High-dollar claims audit

High dollar claims are flagged for manual review by claims examiners and audited before claim payment.

Physician on staff for review of claims

Sanford Health Plan employs doctors and nurses to review claims for the requirement of medical necessity, review claims that may be experimental in nature, or review a quality of care event.

Audit programs

Internal audits are performed on a monthly basis and 2 percent of all claims are audited, with 100 percent review for claims with dollar amounts over $50,000.

Appeals

Sanford Health Plan is compliant with the required timeframes and notice requirements for responding to appeals and grievances as required by the Affordable Care Act.

Telehealth

See a provider without leaving home

Sanford Health Plan Video Visits make it easy for you to connect with a board-certified urgent care provider from the comfort of home. Using your desktop, tablet or mobile device, you can see a provider within minutes, giving you quick, convenient access to quality care.

What to expect

During your visit, a provider can assess your symptoms, develop a treatment plan and send a prescription to your pharmacy of choice, if needed.

$0 Urgent care 24/7*

Our providers can help with common conditions, including:

- Coughs and colds
- Flu-like symptoms
- Sinus congestion and discomfort
- Allergies, skin and eye irritations
- UTIs and bladder infections

Behavioral health

- Take care of your mental health by scheduling a visit with a therapist, psychologist or psychiatrist for concerns such as anxiety, depression or a social disorder.
- Your Sanford Health Plan standard office-visit cost share will apply to these services.

Steps for getting started

Desktop
Visit sanfordhealthplan.com/virtualcare.

Mobile
Search your App Store or Google Play for "Sanford Video Visits" and download the app.

Connect
Sign up or log in. Then, start a visit with a provider anytime, anywhere.

**HSA-qualified High Deductible Health Plans (HDHP) are not eligible for $0 video visits but do qualify for discounted visits for which Health Savings Account (HSA) dollars may be used. $0 24/7 virtual care for acute and non-emergent care through sanfordvideovisits.com. Certain restrictions may apply.*

Cost
The cost of video visits depend on your health insurance coverage. Credit, debit, HSA and FSA are accepted. **Further details at sanfordhealthplan.com/virtualcare.**

Convenient
Connect with a provider 24/7. Referrals and prescriptions are available if necessary.

Quality
All video visit providers are board-certified.

Easy to use
Install the app and sign up to start a visit.

Fitness center reimbursement

The Fitness Center Reimbursement program provides up to $20 monthly reimbursement when your employee and/or their spouse use a participating fitness center at least 12 days per month for fully insured employer groups. The employee and their spouse must carry insurance with Sanford Health Plan to be eligible.

Employees can enroll and manage their accounts online. To enroll for the first time, they will need their Sanford Health Plan member ID card and banking information.

1. Go to **nihcarewards.org** and click on "First Time Enrollment."
2. Search for the desired fitness center location by zip code. Select and click "enroll Online."

Employers will receive a report each month of their employees that received reimbursement that month. An Excel report will be sent via email from "HealthPlanIT-ENG" with a subject line "[Secure] Sanford Health Plan | Fitness Center Taxation Monthly Report" around the 28th of each month.

Privacy and Compliance

HIPAA Compliance

Sanford Health Plan is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic Clinical Health (HITECH) regulations, system and record requirements. Sanford Health Plan has a mature security program that features best practices from security standards such as NIST, ISO, and follows the guidelines and specification of the HIPAA security rule. The Sales and Retention Department, from direction by the policy department, is responsible for coordinating and communicating HIPAA compliant changes to all clients.

Corporate Compliance Program

Sanford Health Plan maintains a corporate compliance program inclusive of its fraud, waste and abuse detection program. Any report or evidence of actual or suspected violations of the law, regulations, or related standards of conduct shall be forwarded to the compliance officer to determine if the circumstances described may constitute a violation or warrant a more detailed investigation.

Security

Sanford Health Plan's primary eligibility and claim adjudication system is fully integrated with the Sanford EpicCare application. As such, it resides on high availability hardware platforms with secondary implementation sites and automated failover. The primary data center is located at the designated IT building, with the failover data center located on the Sanford USD Medical Center campus. Sanford Health Plan disaster recovery leverages the multiple levels of failover options, which exist to support the 24/7 clinical care applications.

Protecting Your Enrollment Information

To protect your enrollment information, please let us know when your Human Resources team changes. This is most important if you are using our myEnrollment portal. You'll also need to notify our vendor partners if you use their services of any changes. Please refer to the contact us page for contact information for HealthEquity and WEX Health.

Your responsibility

Sanford Health Plan is your partner in keeping your health insurance plan compliant. The following information provides you with required disclosures and notices that apply to group health plans subject to ERISA. Sanford Health Plan provides many of these notices to you and your employees. However, you, as an employer, may be required to deliver some items directly to your employees. For example, it is your responsibility to ensure each eligible employee receives the Summary of Benefits and Coverage (SBC) (ordered by your agent) prior to enrollment or during open enrollment. Take the time to become familiar with your responsibilities—indicated as shaded rows in the following table.

Document/notice	Applies to	Content summary	Given to	Timing	Provided by	Where to find it
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Disclosure of Plan Benefits	All group health plans	Description of special enrollment opportunity if eligible for premium assistance under CHIP/ Medicaid	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	1. Policy 2. Annual Member Notice 3. Enrollment Booklet (Special Notices)
Notice to Employees of Premium Assistance under Medicaid or CHIP	All group health plans offered in a state with a CHIP or Medicaid program that provides premium assistance for group health plan coverage	Description of special enrollment opportunity if eligible for premium assistance under CHIP/ Medicaid, including potential opportunities and instructions on who to contact.	All Employees	On or before an employee is initially offered health insurance enrollment	Employer [1]	Enrollment Booklet (Special Notices)
COBRA Election Notice	All group health plans	Notice to "qualified beneficiaries" of their right to elect COBRA coverage upon occurrence of qualifying event (including other coverage options such as the Marketplace).	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	Mailed directly to member by Sanford Health Plan. Also located in Policy.
Notice of Early Termination of COBRA Coverage	All group health plans	Notice that a qualified beneficiary's COBRA coverage will terminate earlier than the maximum period of coverage.	Any member, as applicable	Upon early termination event	Sanford Health Plan (if COBRA administered)	Mailed directly to member by Sanford Health Plan
Notice of Unavailability of COBRA	All group health plans	Notice that an individual is not entitled to COBRA coverage.	Any member or qualified beneficiary, as applicable	Within 14 days of being notified by the employer that the individual experienced a qualifying event	Sanford Health Plan (if COBRA administered)	Mailed directly to member by Sanford Health Plan
Employer Notice to Employees of Coverage Options	All employers subject to the Fair Labor Standards Act	Written notice informing the employee of the Marketplace, the potential availability of tax credits, and the loss of employer contributions (if applicable) when purchasing insurance on the Marketplace. Model Notice: http://www.dol.gov/ebsa/healthreform/regulations/coverageoptionsnotice.html	All New Employees	Within 14 days of hire	Employer	Model notice indicated in "Content summary"

Document/notice	Applies to	Content summary	Given to	Timing	Provided by	Where to find it
External Review Notices	All group health plans	Independent review organization (IRO), or State office administering external appeals must issue a notice of final external review decision	All enrolled members	Timing varies based on claim type and which state/ federal process	Sanford Health Plan or designee	Mailed directly to member by Sanford Health Plan
External Review Process Disclosure	All group health plans	A description of external review processes	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	1. Policy 2. Enrollment Booklet or Renewal Information (Special Notices)
Family and Medical Leave Act (federal FMLA)	All group health plans, if the employer is subject to the FMLA	Describes eligibility and benefits during a FMLA leave and restoration of benefits upon an FMLA return.	All enrolled members	Upon enrollment in the Plan	Employer	Employer Materials
Genetic Information Non-discrimination Act (GINA)	All group health plans	Upon request for medical information, language must be included to specifically direct the individual or health care provider not to provide genetic information.	All Employees and Eligible Dependents	Upon providing materials describing benefits or health coverage	Sanford Health Plan/ Employer	1. Policy 2. Enrollment Booklet (Member Handbook reference) 3. Wellness Documents (if applicable)
Grandfathered Plan Disclosure/Notice[2]	Group health plans claiming grandfathered status	The fact that the plan is grandfathered and includes contact information	All Employees offered coverage	Upon enrollment or renewal in the Plan or when describing benefits/health coverage.	Sanford Health Plan/ Employer	1. Policy 2. SBC 3. Enrollment Booklet or Renewal Packet (Special Notices)
Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices for Protected Health Information (PHI)	All group health plans	Privacy practices and disclosures	All enrolled members	Upon enrollment or renewal in the Plan	Sanford Health Plan	1. Policy 2. Member Annual Notice 3. Enrollment Booklet or Renewal Information (Special Notices)
Internal Claims and Appeals Notices	All group health plans	Notice of adverse benefit determination and notice of final internal adverse benefit determination.	All enrolled members	Timing varies based on claim type and federal/state jurisdiction	Sanford Health Plan	1. Policy 2. Enrollment Booklet or Renewal Information (Special Notices) 3. Explanation of Benefits (EOB)
Medicare Part D Annual Notice	All group health plans that provide prescription drug coverage	Discloses to Medicare-eligible Members (employees and their dependents) whether prescription drug coverage offered is "creditable" or "non-creditable"[3]	All employees	By October 15 of each year (prior to the Medicare Part D Annual Election)[4]	Employer	Given to employer via email from Client Services annually in Sept/Oct.
Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination	All group health plans	Provides the criteria for medically necessary determinations with respect to mental health/substance use disorder benefits	Any current or potential member, beneficiary, or provider upon request	Within 30 days of request	Sanford Health Plan	Mailed directly to requestor by Sanford Health Plan

Document/notice	Applies to	Content summary	Given to	Timing	Provided by	Where to find it
MHPAEA Claims Denial Notice	All group health plans	Provides the reason for any denial of reimbursement or payment for services with respect to mental health/ substance use disorder benefits	Enrolled Member or beneficiary upon request or as required by law	Upon denial and within 30 days of request	Sanford Health Plan	Mailed directly to member by Sanford Health Plan
Michelle's Law Enrollment Notice[5]	All group health plans	A description of the Michelle's law provision for continued coverage during medically necessary leaves of absence	All enrolled members, as applicable	Included with any notice regarding a requirement for certification of student status for coverage under the plan	Sanford Health Plan	Enrollment Booklet or Renewal Information (Special Notices)
Newborns' and Mothers' Health Protection Act (NMHPA) rights in connection with childbirth	Group health plans that provide maternity or newborn infant coverage	A statement describing requirements under Federal or State law, relating to any hospital length of stay in connection with childbirth for a mother or newborn child.	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	Policy
Notice Regarding Designation of a Primary Care Provider (PCP)	All non-grandfathered group health plans that require Primary Care Provider (PCP) designation	Terms regarding designation of PCP and participants' rights to designate any participating PCP who is available to accept the member.	All enrolled members	Upon enrollment in Applicable Plans	Sanford Health Plan	Policy
Plan Policy	All group health plans	Document/contract between Sanford Health Plan and the Member that informs Members about their plan and how it operates, including their benefits, rights, and obligations under the Plan.	All enrolled members	Sent to all Members within 90 days of enrollment[6]	Sanford Health Plan	Policy
Preexisting Condition Exclusion Notices and Certificates of Creditable Coverage	All group health plans	As of 01/01/14, preexisting condition exclusions are prohibited. As of 12/31/2014, plans are no longer required to issue certificate of creditable coverage notices.	N/A	N/A	N/A	See 79 Fed. Reg. 10296-317 (Feb. 24, 2014)
Qualified Medical Child Support Order (QMCSO) Notice/ Disclosures	All group health plans	Disclosure of plan's QMCSO procedures	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	Policy
Notice of Special Enrollment Rights	All group health plans	A description of individuals' special enrollment rights.	All employees	At or before an employee is initially offered the opportunity to enroll	Sanford Health Plan	1. Policy 2. Enrollment Booklet or Renewal Information (Special Notices)
Summary of Benefits and Coverage (SBC) and Uniform Glossary	All group health plans	Describes the benefits and coverage under the plan, and a uniform glossary defining required terms.	All enrolled members	Upon enrollment or renewal in the Plan[7]	Sanford Health Plan or Employer	Enrollment Booklet or Renewal Information
Summary of Benefits and Coverage (SBC) Notice of Modification	All group health plans	Communication of material modification that occurs outside an annual group health renewal.	All enrolled members	At least 60 days prior to effective date	Sanford Health Plan	Mailed directly to member by Sanford Health Plan

Document/notice	Applies to	Content summary	Given to	Timing	Provided by	Where to find it
Transitional Plan Disclosure/Notice[2]	Transitional health plans[8]	Disclosure of continuance of transitional plan and option to enroll in Affordable Care Act compliant plan	Applicable transitional groups	Upon Renewal	Sanford Health Plan	Mailed directly to member by Sanford Health Plan
Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice	All group health plans	Notice of right to elect continuation coverage under USERRA	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	Policy
Wellness Program Disclosure[9]	For group health plans offering a health contingent wellness program in order to obtain a reward	Document outlining reasonable alternative standards or methods in which to waive; including contact information and explanation of other accommodation per member's primary care provider.	All eligible participants	Distributed with enrollment materials[10]	Administrator of wellness program	In any plan materials describing terms of health-contingent wellness programs (activity-only & outcome-based)
Women's Health and Cancer Rights Act (WHCRA) Annual Notice	Group health plans that provide coverage for mastectomy benefits	A simplified disclosure regarding benefits of the four required mastectomy related benefits and how to obtain more information.	All enrolled members	Annually to enrolled members	Sanford Health Plan	Annual notice mailed directly to member by Sanford Health Plan
WHCRA Enrollment Notice and Notice of Benefits	Group health plans that provide coverage for mastectomy benefits	A detailed description of applicable annual deductibles/ coinsurance limitations and the four required mastectomy related benefits and how to obtain more information.	All enrolled members	Upon enrollment in the plan	Sanford Health Plan	Policy
1095-B Forms	All group health plans	A health insurance tax form which reports the type of coverage a members has and the period of coverage for the prior year. Used to verify attainment of minimum qualifying health insurance coverage.	All enrolled members	Annually to enrolled members	Sanford Health Plan	Mailed directly to member by Sanford Health Plan
1095-C Forms	Applicable Large Employers (ALE) (50 or more full-time employees)	A health insurance tax form which provides information about the health care coverage offered by ALE to report compliance with the employer shared responsibility provisions.	All enrolled members	Annually to enrolled members	Employer	Sanford Health Plan will send necessary data for form completion to Employer each year.

[1]***NOTE: the Employer (rather than the group health plan or issuer) is required to provide this notice (29 CFR 2590.701(f)(3)(B)(i)). May be provided with enrollment packets, open season materials, or other materials at or before the time an employee is offered the opportunity to enroll.***

[2]Under the Affordable Care Act, generally, Grandfathered Plans are plans that were in existence and in which at least one individual was enrolled, on 3/23/10. Transitional Plans are plans that were (1) in effect as of 10/01/13, and (2) have received or would otherwise receive a cancellation or termination notice from the issuer. Grandfathered and Transitional plans are exempt from many but not all Affordable Care Act market reforms.

[3]NOTE: This requirement is part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Employer must notify CMS annually as to whether their prescription drug coverage qualifies as "creditable" or "non-creditable". SHP provides annual memo to Employer on notifying CMS and how employer determines coverage is credible.

[4]Medicare beneficiaries who are not covered under "creditable" prescription drug coverage and who chose not to enroll in a Medicare Part D drug plan when they first became eligible for Medicare or during the initial enrollment period, will likely pay a higher premium permanently if they subsequently enroll in the Medicare Part D drug program (the premium is increased by 1 percent for each month without creditable coverage).

[5]NOTE: Under the Affordable Care Act, plans cannot deny or restrict coverage for a child under the age of 26 based on student status.

[6]Updated document must be furnished every 5 years if changes made to information or plan is amended. Otherwise must be furnished every 10 years.

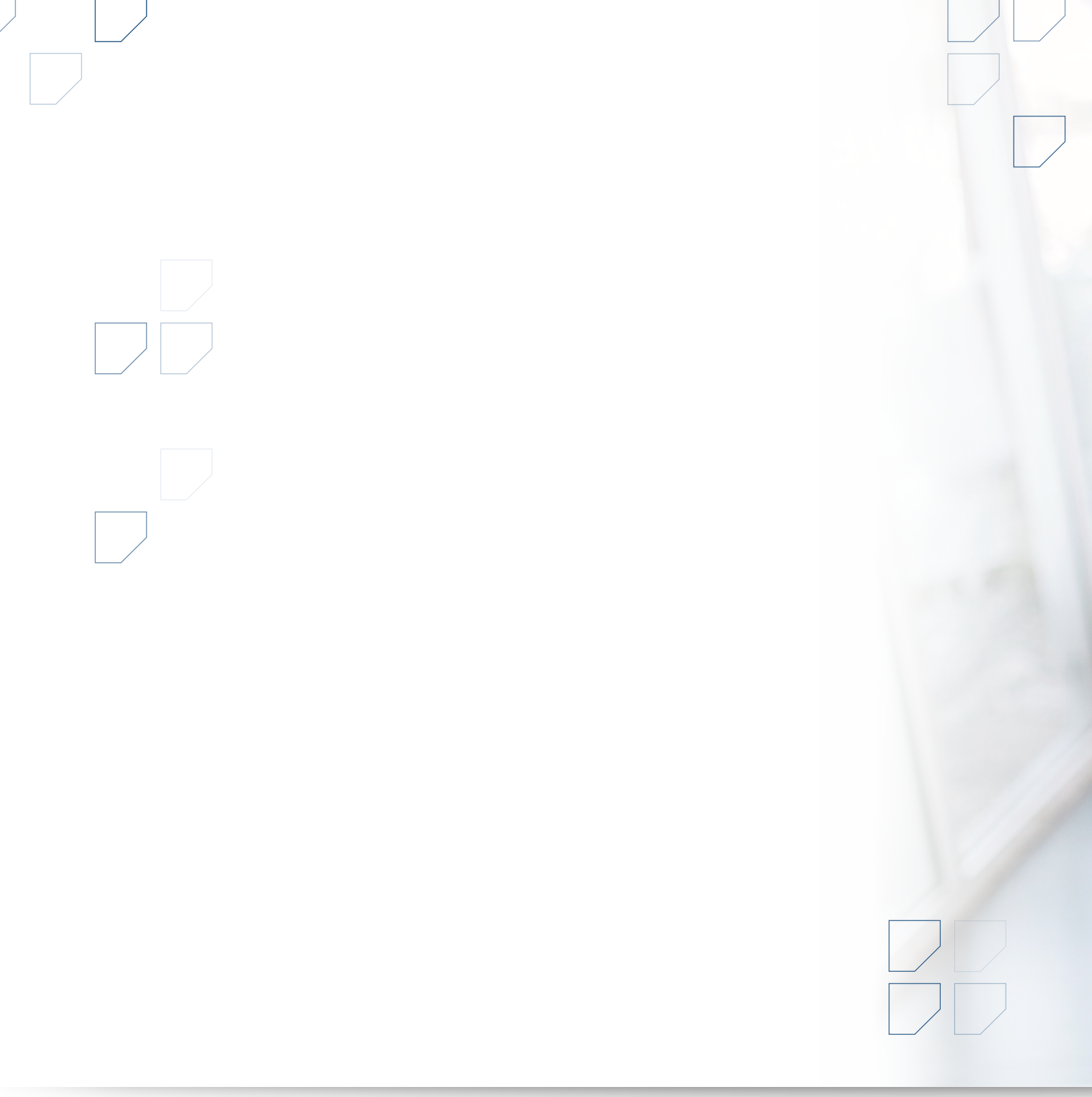
[7]SBC and a copy of the Uniform Glossary must also be provided upon request within 7 days. SBC must be provided to Special Enrollees no later than the date by which the COC/SPD/Policy Document is required to be provided (90 days from enrollment).

[8]Includes large businesses that currently purchase insurance in the large group market but that, as of 01/01/16, will be redefined by §1304(b) of the ACA as "small businesses" purchasing insurance in the small group market

[9]If the plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.

[10]For outcome-based wellness programs, notice must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard.

Legal Disclaimer: This is a general overview based on information currently available. It does not cover all of the requirements, and new information is released frequently. Information and analysis provided by Sanford Health Plan should not be considered legal advice. All information contained herein is for informational purposes only as a service to clients, and is not a substitute for legal counsel. We recommend that you consult with a licensed attorney if you want assurance that the information provided and your interpretation of it are appropriate for your particular situation. The effect of health care reform may differ depending on your circumstances. Sanford Health Plan assumes no liability for the use or interpretation of information contained herein. You should not and are not authorized to rely on analysis provided by Sanford Health Plan as a source of legal or tax advice.



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