# Important Information for Providers about Sanford Health Plan

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sanfordhealthplan.com

SANFORD HEALTH PLAN

Sanford Health Plan (Plan) asks you to take some time and review this information. The following annual notices are required to keep you informed of Sanford Health Plan operations and outcomes.

## Where can I find important Plan information?

If you have any questions...

| | |
|---|---|
| Provider Relations | Phone: (888) 278-6485 (TTY: (888) 279-1549), Monday – Friday, 8 a.m. to 5 p.m. CST<br>Email: providerrelations@sanfordhealth.org |
| Care Management | Phone: (888) 315-0884:<br>Email: shpcasemanagement@sanfordhealth.org |
| Utilization Management<br>NDPERS Utilization Management | Phone: (800) 805-7938 \| TTY/TDD: 711 \| Fax: (605) 328-6813<br>Phone: (888) 315-0885 \| TTY/TDD: 711, Monday – Friday, 8 a.m. to 5 p.m. CST |
| Pharmacy Management<br>NDPERS Pharmacy Management | Phone: (855) 305-5062 \| Fax: (701) 234-4568<br>Phone: (877) 658-9194, Monday – Friday, 8 a.m. to 5 p.m. CST |
| Compliance / Privacy | Phone: (877) 473-0911<br>Email: shpcompliance@sanfordhealth.org |
| Customer Service<br>NDPERS Customer Service | Phone: (800) 752-5863, Monday – Friday, 8 a.m. to 5 p.m. CST<br>Phone: (800) 499-3416, Monday – Friday, 8 a.m. to 5:30 p.m. CST<br>*(After business hours, you may leave a confidential voicemail and someone will return your call the next business day.)* |
| Medicare Advantage Customer<br>Medicare Advantage Health Navigator | Phone: (888) 278-6485 (TTY: (888) 279-1549), Monday – Friday, 8 a.m. to 8 p.m. CST<br>Phone: (877) 701-0788, Monday – Friday, 8 a.m. to 5 p.m. CST |

### Sanford Health Plan's provider webpage (sanfordhealthplan.com/providers) contents:

- Forms, Documents and Manuals link
  - o Provider manual
  - o Contracting and credentialing information
  - o Miscellaneous forms and documents
  - o Request for benefit consideration form
- Referral Center
  - o Provider service form
- Provider News link
  - o Provider newsletters and annual notices
- Medical Services and Drugs Prior Authorization link
  - o Pharmacy benefits/formulary information
  - o Locating a provider or pharmacy
  - o How to prior authorize and what needs prior authorizations
- Provider EDI Resources link
  - o Electronic data interchange services and information
- Clinical Resources link
  - o Behavioral health resources and tools
  - o Clinical resources and tools
  - o Clinical practice guidelines
  - o Preventive health guidelines
  - o Various training and education for practitioners and members including those for our clinical areas of improvement
  - o Cultural Competency Resources
- Quality Improvement Program link
  - o Quality improvement program
  - o HEDIS® report*

### *my*SanfordHealthPlan Provider Portal (sanfordhealthplan.com/providerlogin)

*my*SanfordHealthPlan is Sanford Health Plan's online tool available to providers. Through this secure online tool, you have access to information 24/7 to:

- View copay deductibles, coinsurance and out-of-pocket totals for members
- Verify member eligibility and view covered family member(s)
- Submit medical and pharmacy prior authorizations and online claim reconsiderations
- Access the provider manual and policies
- Check status of claims
- Obtain copies of explanation of payments
- View the HEDIS provider guide and toolkit

To request a *my*SanfordHealthPlan account, follow these steps:

1. Go to sanfordhealthplan.com/providerlogin
2. Click on "Create an Account"
3. Enter all the required account information on the following screens, then click "Finish"

Your information will then be submitted to be reviewed for approval. Once your account has been approved, you will receive an email from Sanford Health Plan. Afterward, you will be able to log on to your provider account using the User ID and Password you created upon setting up your account. If you have any questions or need assistance with setting up an account, please contact Provider Relations.

## Fraud, Waste and Abuse and Related Laws

Sanford Health Plan's (SHP) fraud, waste and abuse policy and program were established to identify and eliminate any fraudulent, wasteful or abusive uses of claims/services perpetrated by employees, members, participating/nonparticipating providers and facilities. Compliance is the responsibility of every employee of SHP, provider and anyone providing services to members of any of SHP benefit plans. Providers should ensure ALL staff, subcontracted staff and vendors are thoroughly educated on state and federal requirements and appropriate compliance programs are in place.

Sanford Health Plan expects First-Tier, Downstream and Related entities (FDRs) (providers) to operate in accordance with all applicable federal and state laws, regulations, Medicare, Medicaid/Medicaid Expansion and Marketplace program requirements including, but not limited to the following:

1. Deficit Reduction Act of 2005
2. Federal and State False Claims Acts (31 U.S.C. §§ 3729-3733)
3. Federal Criminal False Claims Statutes (18 U.S.C. §§287,1001)
4. Civil Remedies False Claims Act 31U.S.C. 22729 - 3372
5. Anti-Kickback Statute (42 U.S.C. § 1320a-7b(b))
6. The Beneficiary Inducement Statute (42 U.S.C. § 1320a-7a(a)(5))
7. Physician Self-Referral ("Stark") Statute (42 U.S.C. § 1395nn)
8. Fraud Enforcement and Recovery Act (FERA) of 2009
9. Social Security Act (United States Code: Social Security Act, 42 U.S.C. §§ 1128c-1128e, 1128k)
10. Minnesota Statutes-609.611 INSURANCE FRAUD
11. South Dakota Code section 58-4A-2: Fraudulent Insurance Acts
12. North Dakota Century Code- CHAPTER 26.1-02.1- INSURANCE FRAUD

** HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS® results do not include elite1 individual plan membership data.*

### FWA Training and Education

All health care practitioners/providers or staff who render health care services are required to complete fraud, waste, and abuse (FWA) training (42 CFR 422.503 and 423.504). Examples of plans include but are not limited to Medicare, Medicaid/Medicaid Expansion, Marketplace, etc.

- The training should be completed upon hire (within 90 days) and annually thereafter. The training will be accepted if taken on the Centers for Medicare and Medicaid Services (CMS) Medicare Learning Network website (MLN). Link to the CMS FWA **and** compliance training slides are listed below.
- MLN General Information - Centers for Medicare and Medicaid Services
    - o cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/MLN-Publications
    - o cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/WebBasedTraining
- All health care practitioners/providers and employees that have taken the trainings should maintain records for 10 years to show completion of these trainings.
- Practitioners/providers who utilize vendor services are responsible to attest their oversight of the vendors, compliance and FWA training/education.

## Reporting

Sanford Health Compliance actively reviews all reports of suspected FWA or noncompliance. To report suspected fraud, waste or abuse and/or suspected compliance issues email SHPCompliance@sanfordhealth.org or call the compliance hotline at (877) 473-0911.

You may also call the toll-free hotline established by the Federal Office of the Inspector General (OIG) in the U.S. Department of Health and Human Services. The hotline number is (800) HHS-TIPS (800) 447-8477). For more information about this hotline and about other ways to contact the OIG, you can go to oig.hhs.gov/fraud/report-fraud/index.asp.

Sanford Health Plan maintains a **NO TOLERANCE** policy in terms of retaliation for anyone reporting issues in good faith; everyone should feel confident that **NO** adverse actions can or will be taken for reporting issues of concern. All issues may be reported anonymously.

# 2022 Quality Improvement Progress Report

Sanford Health Plan and its participating providers are committed to providing high quality health care to our members. For more information on the Plan's QI program and outcomes, see our HEDIS® Report and the Quality Improvement Program summary on our website.

## Our Commitment to Quality

Sanford Health Plan is part of a larger integrated system, Sanford Health, and we are proud to offer Members a variety of resources, information and tools to help improve their health and quality of life. You may receive communications if we feel these programs may suit your needs. Additionally, we perform quality improvement activities and offer Care Management Programs for Members who have more serious health needs.

## Member Feedback

### Member Experience Surveys

The Plan's member experience surveys take place on a yearly basis. These surveys are conducted by an independent survey vendor and provide information on the experiences of our members with the Plan and how well we meet our members' expectations. There are overall ratings of satisfaction in addition to more focused composite scores which summarize survey responses in key areas. The Plan's QI Committee analyzes the results and takes actions for improvement. For more information on the Plan's rates, refer to our HEDIS® Report as referenced in the Website Content section above.

## Population Health Programs

**Wellness Portal:** Sanford Health Plan offers an online wellness portal and mobile app to make it easier to commit to your health and well-being. The Wellness Portal, powered by WebMD, provides a customized well-being experience.
**Health Assessment:** Provides a confidential report about current health status, and gives immediate suggestions and resources to help improving their well-being.
**Daily Habits:** These plans help encourage long-term behavior change by breaking down goals into shorter, actionable steps. There are numerous plans available and each one is customizable.
**Community:** Connect with other members through fun and motivating group chats on a variety of topics including exercise, eating well, reducing stress, sleeping better and finding joy.
**Media Library:** Watch easy-to-follow exercise videos and recipes, listen to engaging mental health podcasts and more.
**Device and App Connection Center:** Automatically upload and track your activity with a fitness device or app.
**Personal Health Record:** A simple way to view all your health information in one place.

Log into your account at **sanfordhealthplan.com/memberlogin. (Forgot username and password options are available, if necessary.)** If you do not have an account, select the "Request Access for Yourself" button. Click Menu, and under the Insurance header, click Portals and Links. Then, select Wellness Portal.

### Better Choices, Better Health® Workshop

If you or someone you care for has chronic, physical or mental health condition, including chronic pain, this free workshop can help you take charge of your life. Meeting weekly for six weeks, you'll get the support you need while finding useful ways to deal with pain, fatigue and stress. The workshop also offers information on good nutrition, exercise, goal setting, and how to talk with your doctor and family to help support your wellness goals.

### Healthy Pregnancy Program

Sanford Health Plan offers education and support for you and your baby. After completing a health assessment with a nurse, we tailor support, tips and tools to help you meet your healthy pregnancy goals. A nurse will also be available to answer any questions about your pregnancy, childbirth and postpartum. Access to Text4baby to help remind you of doctor visits, personalized tips on prenatal care, baby's growth, signs of labor, nursing, eating habits and more. Text BABY (or BEBE) to 511411 to sign up.

**Fitness Center Reimbursements**
Sanford Health Plan will pay up to $20 per Member per month when you use your home fitness center 12 days per month. To sign up, go to **NIHCArewards.org** to enroll online. Under "Member Options", click "First Time Enrollment" and select Sanford Health Plan from the drop down menu. Select your home fitness center location and click "Enroll Online". Read and agree to the terms of service, and enter your contact, health plan and banking information. Click "Submit".

If you visit your home fitness center at least 12 times per month, most participants receive an automatic deposit into a bank account around the 21st of each month. If your fees are less than $20 per month, the credit will reflect the amount you pay each month. You can view the status of your reimbursements in your NIHCA Member account at **NIHCArewards.org**. Please contact your fitness center directly if you find any errors regarding reimbursement. For other errors, please contact Sanford Health Plan for assistance. Please note, it is the Member's responsibility to ensure your gym visits are recorded and payments are received.

If you end your fitness membership or become delinquent in your membership dues, you will not be eligible for reimbursement. If you move your gym membership to a new facility, log on to **NIHCArewards.org** and select your new gym to continue receiving reimbursements.

**Advance Care Planning**
Advance care planning is the process of planning and deciding your future health care in case you are suddenly unable to make your own decisions because of illness or injury. Advance care planning allows you to:

- Think about and discuss treatment options with your family and health care providers to make treatment decisions based on your goals, values and preferences.
- Document and communicate your decisions to those who need to know.
- Select someone you trust to make decisions on your behalf when you are unable to speak for yourself.

Sanford Health Plan encourages all Members to complete an advance directive. A copy should be provided to the person responsible for making decisions in case you cannot speak for yourself, the hospital where you are most likely to receive treatment and your primary provider. For more information and to complete the form, go to **sanfordhealthplan.org/-/media/org/files/patient-education/advance-care-planning.pdf**.

## Member Care Programs
Helping you maintain or improve your health is important and we have many resources to help you reach health goals. Our programs and services were developed to assist in supporting your health goals. These programs and services include medical and behavioral health case management, a health assessment with self-management tools, health coaching, biometric screenings, support for emotional and socially challenging situations and more.

Our programs focus on:

- Promoting colorectal, breast and cervical cancer screenings for eligible members
- Members with chronic health conditions such as obstructive pulmonary disease (COPD), heart failure and coronary artery disease and hypertension to:
- Prevent health complications
- Provide assistance in managing your health
- Ensure your care is coordinated
- Other resources and available programs:
- Healthy Pregnancy Program
- Better Choices Better Health Workshops
- Support for additional preventive health care including cervical cancer screenings and immunizations

If you would like more information about these programs or if you meet criteria to participate, please contact Customer Service or enroll by logging into your secure Member Portal at sanfordhealthplan.com/memberlogin.

**Behavioral Health and Substance Use Disorders**
The Plan's activities to improve follow-up after inpatient treatment for behavioral health and/or substance use disorder discharges, and compliance with antidepressant medications, includes:

Letters sent on a monthly basis to Members who recently started taking antidepressants who have not yet filled their first refill. Education includes medication side effects, compliance, etc. The plan also incorporates depression education/resources into other health management programs as well.

Practitioners are notified of recommended clinical practice guidelines for depression through the provider newsletter and sanfordhealthplan.com.

Our Timeliness of Care Survey included an assessment of sample clinics primarily treating behavioral health and substance use disorders, and their compliance with the Plan's access standards for behavioral health, substance use disorders and appointments. Clinics included in the survey were sent a follow-up letter to notify them of their compliance or noncompliance and educate them on required standards.

The Plan's Behavioral Health Care Managers work with the hospital's discharge planners to arrange a follow-up appointment within seven days of discharge.

The Living Well Member newsletter includes articles on managing chronic health conditions and substance abuse.

The Plan's Pharmacy department refers members with opioid use to Behavioral Health Care Management for case management services.

To increase awareness of available behavioral health and substance use disorder treatment services, Quick Reference Behavioral Health Cards were updated and made available on the website to primary care practitioners to assist in locating Sanford Health Plan participating behavioral health and substance use disorder practitioners in their area.

The Plan also collaborates with behavioral health and substance use disorder treatment professionals and external organizations to ensure the appropriateness of our activities involving behavioral health and/or substance use disorders.

Health Surveys are completed annually and includes an assessment of member satisfaction responses of provider care, access and appointment availability, medication management, and satisfaction of user ability of the Plan's website. From this data, the Plan is able to identify quality improvement activities, implement interventions and measure intervention effectiveness.

**Attention Deficit/Hyperactivity Disorder (ADD/ADHD)**
Sanford Health Plan is committed to improving the rates of appropriate follow-up for Members prescribed ADHD medications by:

- Providing educational materials on symptoms, treatment and follow up recommendations for newly diagnosed Members taking ADHD medications.
- Notifying practitioners of the recommended clinical practice guidelines and providing updated tools (such as Quick Reference Behavioral Health Cards) in the provider newsletter and at sanfordhealthplan.com.

**Adolescent Health**
Adolescent Members and their parent(s)/guardian(s) are provided educational information about the importance of wellness visits and staying up to date on immunizations. Examples include:

- Bright Futures Adolescent Wellness Office Visit Questionnaire
- Immunization schedule is available at sanfordhealthplan.com and updated on an annual basis
- The Living Well Member newsletter featured an article on adolescent well care visits and what the provider will assess. There is also information on how to find a provider in the newsletter article. Practitioners are notified of Clinical Practice Guidelines in the provider newsletter.

**Cancer Screening**
Sanford Health Plan is focused on improving the rates of screening for breast, cervical and colorectal cancers by:

- Annually updating our Preventive Health Guidelines and making them available in the Living Well Member newsletter and at sanfordhealthplan.com and print if requested. Additionally, nurse case managers address preventive screenings during Member conversations when appropriate.
- Notifying practitioners of recommended clinical practice guidelines for cancer screening via the provider newsletter and sanfordhealthplan.com.
- Featuring various cancer screening and plan benefit information in the Member and provider newsletters.
- Sending a postcard to Members of targeted age groups who did not have a colorectal cancer screening. These outlined FIT and Cologuard as a screening option and encouraged Members to speak with their practitioner regarding screening.
- Sent a well woman postcard to female Members to encourage yearly visits and talking with their practitioner about what screenings and/or vaccinations may be appropriate.
- Sending an annual wellness postcard to male members to encourage yearly visits and talking with their practitioners about what screenings and/or vaccinations may be appropriate.

**Tobacco Cessation**
- Member Care Programs, quality improvement activities and the Member Messenger Newsletters stress the importance of smoking cessation and resources available.

- Care Management nurses discuss tobacco use with Members and assist in coordinating resources for tobacco cessation.
- Sanford Health Plan's Wellness Educators are certified as health and wellness coaches; they lead tobacco cessation classes upon request from clients and provide one on one counseling with Members as needed.
- Practitioners are notified of the recommended clinical guidelines for tobacco cessation via the provider newsletter.

**Complex Case Management and CCM Referral Guide**
Sanford Health Plan's Complex Case Management Program is available at no cost to qualifying Plan members and their families. Complex Case Management (CCM) is the coordination of care and services provided to members who have experienced a critical event or have a complex medical condition requiring the extensive use of resources and who need help navigating the health care system. The goal of the CCM program is to assist members in regaining optimum health or improved functional capability by monitoring their care to ensure it follows evidence based clinical standards to promote care gap closure, appropriate use of health care resources and cost-effectiveness. The CCM program involves a comprehensive assessment of the member's condition, determination of available benefits and resources, development and implementation of a case management plan with performance goals, monitoring and follow-up.

**Is there a cost for the CCM program?**
No – Sanford Health Plan's Complex Case Management Program is available to qualifying Plan members and their families at no cost.

**How does the program work?**
A designated case manager is responsible for managing these complex cases to ensure high quality, cost-effective and appropriate utilization of health services. Case managers act as member advocates, seeking and coordinating creative solutions to meet health care needs without compromising quality health outcomes for selected medical diagnoses. The case manager contacts our members by phone or mail and acts as a resource, educator and coordinator of medical services.

**What qualifies a member for the program?**
Concentrating for the most part on catastrophic or chronic cases, case managers consult and manage:

- Multiple chronic illnesses (e.g., diabetes and cardiovascular problems) and/or chronic illnesses resulting in high utilization
- Individuals with physical or developmental disabilities or severe injuries
- High risk or complicated medical or behavioral health conditions
- Multiple re-admissions

**How do I refer a Sanford Health Plan member for the program?**
If you would like more information about CCM, or if you would like to refer a qualified Sanford Health Plan member for the program, please contact our Care Management department.

For Sanford practitioners: If a Plan case manager is currently following a member, the case manager will be listed on the patient care team in One Chart. Please feel free to use in-basket messaging to contact the Plan case manager directly. You can also send an in-basket message to "SHP CRM Complex Case Management" if you are unable to determine the assigned case manager.

## Clinical Practice Guidelines

Sanford Health Plan is responsible for adopting and distributing clinical practice guidelines for acute, chronic and behavioral health care services that are relevant to our membership. The Plan's multi-specialty physician committee, the Physician Quality Committee, has reviewed, approved and updated practice guidelines for numerous conditions for use as the Plan's primary clinical practice guidelines.

Please visit our website at sanfordhealthplan.com/providers/resources to find links to the adopted guidelines. If you have any questions or suggestions regarding these guidelines, or to request a copy of the guidelines, please call Provider Relations.

## Preventive Health Guidelines

Sanford Health Plan recognizes that health promotion and disease prevention are the best opportunities to reduce the ever-increasing portion of resources spent to treat preventable illnesses and impairments. As a Plan, we want to educate our members on how to cut health care costs, prevent premature onset of disease and disability, and to help all members achieve healthier and more productive lives.

Preventive Health Guidelines are age- and gender-specific. They describe prevention or early detection interventions, recommendations for frequency and conditions under which the interventions are required. Appropriate practitioners are

involved in the development of preventive health guidelines (i.e., practitioners who are from specialties that would use the guidelines).

Members of Sanford Health Plan are encouraged to utilize preventive health services, health education and health promotion through preventive health services, educational classes and other articles on prevention in special mailings or in the Member Messenger newsletters.

Current Preventive Health Guidelines are available on our website at sanfordhealthplan.com/providers/resources for both members and practitioners (the practitioner version includes the codes that are to be used for these preventive services). A paper copy is available by calling Provider Relations.

## Utilization Management (UM)

Utilization Management (UM) decision-making is evidence-based and reviewed for medical necessity in accordance with Plan coverage. Sanford Health Plan does not reward practitioners or other individuals conducting utilization review for issuing denials. Financial incentives are not offered to UM decision-makers, and do not encourage any decisions that result in under-utilization, nor denials of service or coverage. Decision-makers sign an "Affirmative Statement Regarding Incentives" verifying the above conditions.

**Physician or pharmacist reviewer availability**
A physician or pharmacist reviewer is available by phone to any practitioner to discuss determinations based on medical appropriateness.

**Services that require pre-approval (pre-authorization/certification)**
Inpatient hospital or other facility admissions, including medical, surgical, neonatal intensive care nursery, mental health and/or substance use disorders; select outpatient services, home health services, skilled nursing and sub-acute care, transplant and oncology services, prosthetic limbs, genetic testing, insulin infusion devices, high-end imaging, requests to non-participating providers recommended by participating providers, dental anesthesia (for certain ages and conditions), bariatric surgery (if a covered benefit), and/or external hearing aids (that is not due to the gradual deterioration that occurs with aging or other lifestyle factors) if a covered benefit. For a more complete listing of services that require prior authorization, please visit sanfordhealthplan.com/providers/prior-authorization.

Not all services prescribed or recommended by yourself or health care practitioner may be covered by the Plan.

**Services**
Admission before the day of non-emergency surgery will not be covered unless the early admission is medically necessary and specifically approved by Sanford Health Plan.

**Points to remember:**

- All requests for authorization are to be made by the provider's office at least three (3) working days prior to the scheduled admission or requested service. In the event that health care services need to be provided within less than three (3) working days, contact the Utilization Management department to request an expedited review.
- All referrals to non-participating providers (at the recommendation of a participating provider) require prior authorization.

**How to request Pre/Prior Authorization**
Prior authorizations for health care services should be obtained online by logging in to the mySanfordHealthPlan provider portal at sanfordhealth.org/Provider. Open the member record and choose "Create Referral". The tutorial explaining how to request a prior authorization is located within the provider portal.

NOTE: Oncology treatment and services must be entered and authorized through eviti|Connect online at eviti.com. Highend imaging services for select members and health plans must be entered and authorized through eviCore at evicore.com.

- Online: Select "Authorizations" in your secure mySanfordHealthPlan account. Click on either "Submit a Pharmacy Preauthorization" or "Submit a Medical Preauthorization" depending on your request. Once you complete the required information click "Submit."

**Criteria**
Every year, the Plan's Physician Quality Committee reviews the Plan's medical policies and procedures, quality programs and clinical practice guidelines. The Physician Quality Committee is charged with supporting the Plan's Board of Directors and Senior Director, Medical Services in meeting quality assurance goals on issues of care.

The Committee consists of physician members from various specialties, including a behavioral health practitioner, and meets at least six times a year. The Plan's Senior Director, Medical Services reports on the Committee's activities to the

Board of Directors on a quarterly basis. The Committee is actively involved in the development of quality initiatives and health management programs. It is also responsible for approving and annually reviewing utilization management criteria. Any recommended changes in the criteria or any other program changes are approved by the Board of Directors.

The Pharmacy and Therapeutics Committee is charged with supporting the Plan's Board of Directors and Senior Director, Medical Services in meeting quality assurance goals on pharmaceutical coverage. The Committee membership consists of physicians and pharmacists representing retail and hospital-based pharmacies. Specific specialty physicians are also invited to attend meetings per drug topic or disease managed state reviewed if current Committee membership does not support the topic up for review. The Pharmacy Benefit Manager (PBM) has an assigned clinical pharmacist that actively participates in all aspects of formulary development, ongoing management, and resource management. Sanford Health Plan employs clinical pharmacists to assist in the day-to-day management of the pharmacy program. No incentives are given to providers or pharmacists for using specific drugs. Sanford Health Plan currently does have some mandated generic substitution programs in place in their pharmacy benefit program, as well as some step-therapy protocols for multiple drug categories.

All practitioners are welcome to have input into the activities of both committees. Suggestions concerning quality programs, health management programs, clinical practice guidelines, and utilization management criteria are welcome and can be directed to the Senior Director, Medical Services by mail or by phone at (605) 328-6807 or (800) 805-7938.

To access medical policy criteria, providers may log into our Cite Transparency® through the Provider Portal at sanfordhealthplan.com/providerlogin to access. You may also request a copy of the criteria used by contacting the Utilization Management Department.

## New medical technologies/new applications for existing technologies, experimental/investigational procedures

To ensure members access to safe and effective care, Sanford Health Plan has adopted a process to evaluate and address new developments and new technology in medical and behavioral health procedures, pharmaceuticals and devices.

The Physician Quality Committee is responsible to recognize and evaluate new health care services, medical and behavioral health procedures, pharmacological treatments and devices as well as their application for the Plan members.

The Physician Quality Committee includes a practitioner who specializes in behavioral health care in this decision-making process. A specialist representing the new technology (i.e. physician, pharmacist, etc.), if not a member of the Committee, may be invited to present the technological aspects of the service/procedure/pharmacological treatment, as needed.

Published scientific evidence and information from literature and the internet will be reviewed to make the appropriate decisions. The technology must have final approval from appropriate government regulatory bodies. Investigational and experimental treatments/medications will not be approved for usage under the Sanford Health Plan Benefits Policy guidelines.

To be eligible for consideration of coverage all of the following must be met:

1. The technology must have final approval from appropriate government regulatory bodies (i.e. FDA).
2. The published scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. (literature, internet or specialist review).
3. The technology must improve net health outcomes.
4. The technology must be at least as beneficial as all established alternatives.
5. The health benefit must be attainable outside an investigative setting.
6. External health care experts utilized in the review process shall include licensed or qualified health care professionals in the field of study or treatment for which the experimental treatment review is taking place, i.e., licensed chiropractors will review experimental/investigative treatments in the area of chiropractic care.

This review will start with the completion and submission of the Request for Benefit Consideration form (Forms, Documents and Manuals link) that will be reviewed for medical content and prioritization. This process will consider factors such as medical impact, safety, efficacy, clinical trial phase, and cost-to-benefit ratios. After submitting the Request for Benefit Consideration form, it may take several months to be incorporated into a covered benefit option.

The completion of the Request for Benefit Consideration form does not guarantee coverage of benefits, and the request must be completed prior to claim submission of the new product or service.

The next step is the determination of coverage or a denial. This step will be a review by many departments in the Plan. Once the coverage options are discovered, it will move onto a Physician Quality Committee review. Once the new technology or new application of an existing technology has been reviewed by the Physician Quality Committee, this review can result in either of two types of decisions:

1. A policy determination to include a new technology as a covered benefit in the future. The Medical Management policy that uses the MCG (Milliman Care Guidelines) criteria will be developed by the Medical Management staff and will be presented at the same time. This would become the policy for this new health care service, medical and behavioral health procedure, pharmacological treatment or device.
2. A case-based decision on whether or not to cover a specifically requested service. There must be evidence that case-based decisions result in a review of medical necessity guidelines and procedures for possible revision.

Upon approval from the Board of Directors, Sanford Health Plan will notify practitioners by way of the newsletter, if appropriate.

The Senior Director, Medical Services and the Physician Quality Committee will consider all requests for coverage based on the Benefits Policy guidelines. If you would like more information on either of these policies, please contact Utilization Management.

## Pharmacy and Formulary information

The Sanford Health Plan Pharmacy Department will help you get the most out of your medication benefits. The Sanford Health Plan Formulary is a list of FDA approved brand-name and generic medications chosen by health care providers on the Pharmacy and Therapeutics (P and T) Committee. Selection criteria include clinical efficacy, safety, and cost effectiveness. Changes are made throughout the year as warranted, with a complete review performed each year.

A listing of the formularies, medications requiring step therapy, medications requiring prior authorization, and a link to pharmacy directories are available online at sanfordhealthplan.com/providers/pharmacy-information.

**To be covered, medications must be**

1. Approved and prescribed by a licensed health care professional (physician, physician assistant, nurse practitioner, or dentist) within the scope of his or her practice.
2. Listed in the Plan Formulary, unless unless an exception or a prior authorization is given by the Plan.
3. Provided by an in-network pharmacy except in the event of a medical emergency.
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

**Formulary Designs**

Depending on the plan, prescriptions may apply toward a tiered copay structure when choosing generic or preferred brand name medications, or medications may go toward the deductible if it's a high deductible health plan. If the benefit plan offers tiered formularies, the higher the tier means the higher the copay/cost-share (except for high-deductible HSA plans).

**2-Tier Formulary**

- Tier 1: generic medications
- Tier 2: covered brand name medications

**3-Tier Formulary**

- Tier 1: generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications

**4-Tier Formulary**

- Tier 1: generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications
- Tier 4: specialty medications*

**5-Tier Formulary**

- Tier 1: preferred generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications
- Tier 4: preferred specialty medications*
- Tier 5: non-preferred specialty medications*

**6-Tier Formulary**

- Tier 1: preferred generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications
- Tier 4: generic/preferred biosimilar specialty medications*
- Tier 5: preferred specialty medications*
- Tier 6: non-preferred specialty medications*

*Specialty medications may include original reference product, generics (if applicable), or biosimilar (if applicable).

## Specialty Pharmacies

Specialty pharmacy options include in-network retail pharmacies located in North Dakota, Sanford Pharmacies, Optum Specialty Pharmacy, and Monument Health Specialty Pharmacy.

## Pharmacy Procedures

### Specialty Medications

Specialty medications are typically used to treat complex medical conditions. These medications may require frequent dosing adjustments, close monitoring, special training, or compliance assistance. In addition, specialty medications may need special handling and/or administration, and may have limited or exclusive product availability and distribution. Specialty medications can be obtained through: in-network retail pharmacies located within the state of North Dakota, Sanford Specialty Pharmacy, Optum Specialty Pharmacy, or Monument Health Specialty Pharmacy.

### Generic Medications

By following the formulary and asking your provider for generic medications when available, you will save money and help control the costs of your healthcare. If you request a brand name medication when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic product, in addition to any copay and/or cost-share as determined by your plan benefits.

### Medication Step Therapy Program

A program that requires certain medications to be used in a specific order, or by "steps." If there's a trial of a "first-step" medication and it does not work, the member experiences adverse side effects, or any of the other exceptions listed in the Step Therapy policy, then the next step medication may be tried, etc. This program is designed to save the member money by trying alternative medications before more expensive medications are used.

### Quantity Limit/ Amount Allowed

Medication may be limited to a certain quantity.

### Pre/Prior-Authorization of medication (Pre/Prior-Authorization/certification)

Select medications require Pre/Prior-Authorization before coverage. Pre/Prior-Authorizations for medications may be obtained by contacting the Pharmacy Management Department:

- **Online:** Providers: Select "Authorizations" in your secure mySanfordHealthPlan account when you open the member's information. Step by Step instructions are available with the mySanfordHealthPlan Provider Portal.
- **Fax:** Fax the Prescription Drug Prior Authorization Request and Formulary Exception Form and supporting documentation (this form is REQUIRED for all requests submitted via fax).

### Exceptions to the Formulary

If the member, or you, as their health care practitioner, feels that a certain non-formulary medication is medically necessary for their condition, an exception may be available. They must first try formulary medications before an exception to the formulary will be made for non-formulary medication, unless the member has contraindications to all covered formulary medications or there is a specific clinical basis where the formulary medications are not appropriate (clinic notes documenting the contraindications or clinical basis for exception must be provided). To request an exception, you, as their provider, must complete the Prescription Drug Prior Authorization Request and Formulary Exception form, and return to Sanford Health Plan (along with supporting clinical documentation), or submit an exception request through the Provider Portal at sanfordhealthplan.com/providerlogin. Requests will be reviewed and the member and provider will be notified of the determination by mail. For urgent requests, or requests for members with MN-based benefit plans, the determination will also be communicated via telephone or telecommunication device.

The Plan will use appropriate pharmacists and/or practitioners to consider exception requests and promptly grant an exception to the formulary, including exceptions for anti-psychotic and other behavioral health medications, when the health care practitioner prescribing the medication indicates to the Plan that:

1. The formulary medication causes an adverse reaction in the patient;
2. The formulary medication is contraindicated for the patient; or
3. The prescription medication must be dispensed as written to provide maximum medical benefit to the patient.

If there is an adverse determination regarding the request, or if there is a wish to appeal, please follow the Complaints and Appeals Procedure and the External Review Rights, located in the Provider Manual. This applies to requests for coverage of non-covered medications, generic substitutions, therapeutic interchanges and step-therapy protocols.

### Over-the-counter medications, vitamins and/or supplements

Medications that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and only when prescribed by a health care practitioner and/or provider are available at a $0 copay (no member cost-share) if the member meets specific conditions, such as age or gender. If the member does not meet the specific conditions, the usual member benefit will apply.

**Medical benefit**
Medications covered under the medical benefit that are subject to the medical deductible, coinsurance and maximum out of pocket.

**Generic substitutions/therapeutic interchange**
To promote value optimization, the formularies generally endorse the use of generic medications over their brand counterparts, whenever possible. Where most substitutions for generic/therapeutic interchange occur outside the purview of the health plan, specific policies related to brand ancillary penalties are maintained separately. The purpose of these policies is to standardize the review process for cases where a brand may be medically necessary, in order to bypass these ancillary penalties.

**Formulary Updating**
The Plan updates the formulary on an annual basis and as needed when new drugs enter the market or when a drug is removed from the market, as described in the Pharmacy and Therapeutics Committee's responsibilities.

**Pharmacy Management Staff Updating**
Those who handle pharmacy benefit inquiries are provided updated formulary change information prior to the effective date of change. Notifications and training (if necessary) are provided through email and/or staff meetings. The Pharmacy Management Team also has access to the PBM Early Systems Delivery (EDI) in handling pharmacy benefit inquiries, which contains accurate and current formulary information as changes are made.

**Practitioner Updating**
- The notice must include a description specific enough to give readers a clear idea of the topic and the general content and must include a link or direction to the specific information. Sanford Health Plan may group or summarize the information by theme.
- Direct emailing to practitioners by newsletter is done on a yearly basis with information on how to access the formulary and pharmaceutical management procedures on the website/portal or to call for a copy. If email doesn't exist for said practitioner, a postcard will be sent that refers them to the Plan website, or to call the Plan for a copy.
- The provider manual includes contact information for the pharmacy management team, instructions on how to access the formulary online, and a description of the formulary exception process.
- Sanford Health Plan's mySanfordHealthPlan portal contains an overview of medication benefits, formularies and descriptions of the formulary exception process including providing information to support their exception request, step therapy program, prior authorization process, generic substitution and therapeutic interchange.
- Providers may also obtain this information by contacting the pharmacy management or provider elations departments.
- General notice of removal of drugs from the formulary includes member and practitioner notification as these changes occur, or at least annually as the formulary is updated for the following year.

**Member Updating**
Upon enrollment, all members are provided a member handbook and summary of pharmacy benefits by
- The employer group human resources department.
- Or through direct mail by newsletter on a yearly basis that includes information on how to access the formulary and pharmaceutical management procedures on the website/portal or to call for a copy. If email doesn't exist for said member, a postcard will be sent that refers them to our website or to call the Plan for a copy.

***my*SanfordHealthPlan Website Portal**
The member has confidential access to their pharmacy account via the PBM link on our portal. This site can be accessed 24 hours a day, seven days a week. The website provides the member with formulary information including covered and not covered drugs, copay information, quantity level limits, prior authorization information, exception request process including providing information to support this request, use of generic substitution, therapeutic interchange or step-therapy protocols, etc.

**Contacting the Pharmacy Management Department**
General notice of removal of drugs from the formulary is sent via the member newsletter as these changes occur or at least annually as the formulary is updated for the following year.

Members who are directly affected by a removal of a drug from the formulary are sent a letter with information about the change, the effective date of the removal, and the alternative drugs available to them, prior to the drug being removed from the formulary.

**For more detailed pharmacy information**
Please refer to the Pharmacy Information link for the following documents for specific medication coverage information. Members received this information upon enrollment, but copies may also be obtained (1) online on our Provider Portal or (2) by calling Customer Service.

1. Summary of Benefits and Coverage – describes the payments for which members are responsible when purchasing prescription medications and supplies;
2. Policy/SPD/COC/COI – describes how and where to obtain prescription medications and supplies, dispensing limitations, and excluded medications and supplies.
3. Covered Medication List or Formulary– list containing the most commonly prescribed medications that are covered under a member's benefit plan (for the complete list, or for specific details about drug coverage, login to the Provider Portal and click "Covered Medication List" under the specific member.)

Please contact us at least three days before the requested service to ensure timely processing of your request.

In the event that health care services need to be provided within less than three (3) working days, contact the Utilization Management Department to request an expedited review. Admission the day before a non-emergency surgery will not be covered unless the early admission is medically necessary and specifically approved by Sanford Health Plan. Coverage for hospital expenses prior to the day of surgery at an out-of-network facility will be denied unless authorized prior to being incurred.

## Filing Claims

Sanford Health Plan participating providers are required to submit claims on members' behalf. Claims should be submitted to Sanford Health Plan. We encourage you to transmit claims electronically for faster reimbursement and increased efficiency. Accepted claims forms are a standard CMS, UB or ADA claim. Submitting these forms with complete and accurate information ensures timely processing of your claim. All claims should be submitted using current coding and within 180 days, or as defined in your contract, even if the member has exceeded their deductible or copay amounts. For more information on what EDI transactions are available to you through Sanford Health Plan, see the 'Provider EDI Resources' page on our website, or view the information in the provider manual.

**Paper Claims Submission**
If you cannot file claims electronically, paper claims may be mailed to:

Sanford Health Plan Claims Department
PO Box 91110
Sioux Falls, SD 57109-1110

To improve our turnaround time and accuracy of paper claim processing, we use a scanning procedure through the Smart Data Solutions (SDS) system. It is important for you to know that the SDS system uses optical character recognition (OCR). Therefore, when OCR is used, your provider name must match our records in order for the system to correctly identify the "pay to" information. If a mismatch occurs, or if the claim cannot be read, you will receive a letter from SDS asking you for the missing or illegible information. A prompt response will prevent further delay in processing your claim. When sending paper claims, please follow the 'Paper Claims Submission' guidelines outlined in the Provider Manual.

## Member Rights and Responsibilities

**Important Member Enrollee Information (Minnesota Plan Members Only)**

The HMO coverage described in a Member's policy may not cover all their health care expenses. Providers can review the policy in detail or contact Customer Service to determine which expenses are covered.

**The laws of the state of Minnesota provide Members of an HMO certain legal rights, including the following:**

1. These are network services provided by participating Sanford Health Plan network providers or authorized by those providers. Your Policy fully defines what services are covered and described procedures you must follow to obtain coverage.
2. Enrolling with Sanford Health Plan does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the Sanford Health Plan network, you must choose amount from remaining Sanford Health Plan network providers.
3. Certain services are covered only upon referral. See section (section number) of your contract for referral requirements. All referrals to non- (name of health maintenance organization) providers and certain types of health care providers must be authorized by (name of health maintenance organization).
4. Emergency services from providers outside the Sanford Health Plan network will be covered only if proper procedures are followed. Read this Policy for the procedure, benefits and limitations associated with emergency care from Sanford Health Plan network and non-Sanford Health Plan network providers.

5. Certain service or medical supplies are not covered. Read this Policy for a detailed explanation of all exclusions.
6. You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your contract.
7. These are network services provided by participating Sanford Health Plan network providers or authorized by those providers. Your Policy fully defines what services are covered and described procedures you must follow to obtain coverage.
8. Enrolling with Sanford Health Plan does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the Sanford Health Plan network, you must choose amount from remaining Sanford Health Plan network providers.
9. Certain services are covered only upon referral. See section (section number) of your contract for referral requirements. All referrals to non- (name of health maintenance organization) providers and certain types of health care providers must be authorized by (name of health maintenance organization).
10. Emergency services from providers outside the Sanford Health Plan network will be covered only if proper procedures are followed. Read this Policy for the procedure, benefits and limitations associated with emergency care from Sanford Health Plan network and non-Sanford Health Plan network providers.
11. Certain service or medical supplies are not covered. Read this Policy for a detailed explanation of all exclusions.
12. You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your contract.

**ENROLLEE BILL OF RIGHTS (Minnesota Plan Members Only)**

1. Enrollees have the right to available and accessible services including emergency services, as defined in your contract, 24 hours a day and seven days a week.
2. Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice.
3. Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law.
4. Enrollees have the right to file a complaint with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers.
5. Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force.
6. Medicare enrollees have the right to voluntarily dis-enroll from the health maintenance organization and the right not to be requested or encouraged to dis-enroll except in circumstances specified in federal law.
7. Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

**Member Rights and Responsibilities**

Each Member (or Member's parent, legal guardian or representative) have the following rights and responsibilities. Please check your policy for a full list of your rights and responsibilities.

1. A right to receive information about Sanford Health Plan, its services, its practitioners and providers and member rights and responsibilities.
2. A right to be treated with respect and recognition of your dignity and right to privacy.
3. A right to participate with practitioners in making decisions about your health care.
4. A right to a candid discussion of appropriate or medically necessary treatment options for your conditions, regardless of cost or benefit coverage.
5. A right to voice complaints or appeals about Sanford Health Plan or the care we provide.
6. A right to make recommendations regarding Sanford Health Plan's member rights and responsibilities policy.
7. A responsibility to supply information (to the extent possible) that Sanford Health Plan and our practitioners and providers need to provide care.
8. A responsibility to follow plans and instructions for care that you have agreed to with your practitioners.
9. A responsibility to understand your health problems and participate in developing mutually agreed-upon treatment goals, to the degree possible.

# Non-discrimination notice

SANFORD HEALTH PLAN

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law.

Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages
- If you need these services, call (800) 752-5863 (TTY: 711)

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with the Section 504 Coordinator at:

Mailing Address: Section 504 Coordinator, 2301 E. 60th Street, Sioux Falls, SD 57103
Telephone number: (877) 473-0911 (TTY: 711)
Fax: (605) 312-9886
Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by phone, mail, fax, or email. If you need help filing a grievance, the Section 504 Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)

Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

# Help in Other Languages

For help in any language other than English, call (800) 752-5863 (TTY: 711).

**Arabic** – ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم (800) 752-5863 (رقم هاتف الصم والبكم:711)

**Amharic** – ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶችማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (800) 752-5863 (መስማት ለተሳናቸው:711).

**Chinese** – 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 (800) 752-5863 (TTY: 711)。

**Cushite (Oromo)** – XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 752-5863 (TTY: 711).

**German** – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 752-5863 (TTY: 711).

**Hmong** – LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 752-5863 (TTY: 711).

**Karen** – ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤနှ်ၤ ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး (800) 752-5863 (TTY: 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 752-5863 (TTY: 711) 번으로 전화해 주십시오.

**Laotian** – ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 752-5863 (TTY: 711).

**French** – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 752-5863 (TTY: 711).

**Russian** – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 752-5863 (телетайп: 711).

**Spanish** – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 752-5863 (TTY: 711).

**Tagalog** – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 752-5863 (TTY: 711).

**Thai** – เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 752-5863 (TTY: 711).

**Vietnamese** – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 752-5863 (TTY: 711).