South Dakota

Large Group True

Certificate of Coverage

PLEASE NOTE: This Contract has no Out-of-Network coverage except when Urgent or Emergent Care is Medically Necessary. Please read this Certificate of Coverage carefully and pay close attention that you are receiving care from In-Network Participating Practitioner and/or Providers.

Help understanding this document is free.

If you would like this Certificate in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 752-5863 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*.

Help in a language other than English is also free.

Please call (800) 892-0675(800) 892-0675 *(toll-free)* to connect with us using free translation services.

Plan on the best fit.

sanfordhealthplan.com

SANFORD HEALTH PLAN

Amendment to Your Health Benefits
South Dakota Large Group

PO Box 91110
Sioux Falls, SD 57109
Toll-free: (800) 752-5863
TTY/TDD: 711*(toll free)*
sanfordhealthplan.com

SANFORD HEALTH PLAN

This Amendment is effective January 1, 2026, and applies to coverage for the South Dakota Commercial, PLUS, and TRUE Certificates of Coverage. Please review this document carefully and keep it with your Certificate of Coverage for future reference.

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Summary Notice

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

MODIFIED

This Notice of Privacy Practices ("Notice") applies to Sanford Health Plan and Security Health Plan. If you have questions about this Notice, please contact Sanford's Privacy Office at 1-800-325-9402. You may also email your questions to privacyoffice@sanfordhealth.org.

This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by Sanford Health Plan and Security Health Plan, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a member under a policy or contract, or a prospective member, obtained by Sanford Health Plan or Security Health Plan from that person or from a health care provider is confidential and may not be disclosed except as set forth below.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We use or disclose your health information as follows (In Minnesota we will obtain your prior consent):

- **Help manage the health care treatment you receive:** We can use your health information and share it with professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional services.
- **Pay for your health services:** We can use and disclose your health information for the payment of your health services. For example, we share information about you with your provider to coordinate payment for those services.
- **For our health care operations:** We may use and share your health information for our day-to-day operations, to improve our services, and contact you when necessary. For example, we use health information about you to develop better services for you. We may also use and disclose your protected health information to determine premium costs, underwriting, rates and cost-sharing amounts, provided that no genetic information may be used for underwriting purposes. This does not apply to long-term care plans.
- **Administer your plan:** We may disclose your health information to your health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

We may share your health information in the following situations unless you tell us otherwise. If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest or needed to lessen a serious and imminent threat to health or safety:

- **Friends and Family:** We may disclose to your family and close personal friends any health information directly related to that person's involvement in payment for your care.
- **Disaster Relief:** We may disclose your health information to disaster relief organizations in an emergency.

We may also use and share your health information for other reasons without your prior consent:

- **When required by law:** We will share information about you if State or federal law require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law. This may include disclosing information about victims of abuse, neglect, or domestic violence.
- **Law enforcement:** We may share information for law enforcement purposes. This includes sharing information to help locate a suspect, fugitive, missing person or witness.
- **For public health and safety:** We can share information in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone's health or safety.
- **Lawsuits and legal actions:** We may share information about you in response to a court or administrative order, or in response to a subpoena.
- **Organ and tissue donation:** We can share information about you with organ procurement organizations.
- **Medical examiner or funeral director:** We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers' compensation, correctional institutions and other government requests:** We can share information with employers for workers' compensation claims. We also share information with correctional institutions about their inmates. Information may also be shared with health oversight agencies when authorized by law, and other special government functions such as military, national security and presidential protective services.
- **Research:** We can use or share your information for certain research projects that have been evaluated and approved through a process that considers a member's need for privacy.

We may contact you in the following situations:

- **Treatment options:** To provide information about treatment alternatives or other health related benefits, providers or services that may be relevant to your care.
- **Fundraising:** We may contact you about fundraising activities, but you can tell us not to contact you again.

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION

When it comes to your health information, you have certain rights.

- **Get a copy of your health and claims records:** You can ask to see or get a paper or electronic copy of your health and claims records and other health information we have about you. We will provide a copy or summary to you usually within thirty (30) calendar days of your request. We may charge a reasonable, cost-based fee. Access may be denied in some circumstances or when a certain law prohibits your access. In some circumstances you may have this decision reviewed.
- **Ask us to correct your health and claims records:** You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we'll tell you why in writing. These requests should be submitted in writing to the contact listed below.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be approved. We must say "yes" if the disclosure of your information could endanger you.
- **Ask us to limit what we use or share:** You can ask us to restrict how we share your health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six (6) years prior, who we've shared it with, and why. We will include all disclosures except for those about your treatment, payment, and our health care operations, and certain other disclosures (such as those you asked us to make). We will provide one (1) accounting a year for free, but we will charge a reasonable cost-based fee if you ask for another within twelve (12) months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you**: If you have a designated health care agent or medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- **File a complaint if you feel your rights are violated:** You can complain to the U.S. Department of Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.

Contact Information:

Sanford Health Plan
Customer Service
PO Box 91110
Sioux Falls, SD 57109-1110
(800) 752-5863 (toll-free) | TTY/TDD 711

Security Health Plan
Customer Service
1515 North Saint Joseph Avenue
P.O. Box 8000
Marshfield, WI 54449-8000
(800) 472-2363 (toll-free) | TTY/TDD 711

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

- We are required by law to maintain the privacy and security of your health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this Notice and offer to give you a copy.
- We will not use, share, or sell your information for marketing or any purpose other than as described in this Notice unless you tell us to in writing. You may change your mind at any time by letting us know in writing.

CALLING, TEXTING, AND EMAILING

We may contact you about your plan and health care using the phone numbers and email addresses that you provide to us. This may include using an automated phone dialing system, pre-recorded or synthetic voice messages, texting, or email. When we contact you in this manner, you will be given the opportunity to opt out of receiving similar communications going forward.

Because texts and emails are not encrypted, there is a risk that someone else could read or access these messages. We therefore take steps to limit the amount of health information that they contain. You may choose to opt out of these messages at any time.

NOTICE OF AFFILIATED COVERED ENTITY DESIGNATION

Sanford Health Plan, Security Health Plan, Sanford Health, Marshfield Clinic Health System, and The Evangelical Lutheran Good Samaritan Society, as covered entities under common ownership and control, have designated themselves and subsidiaries as a single covered entity for purposes of the Health Insurance Portability and Accountability Act (HIPAA). Sanford Health Plan and Security Health Plan share health information about members with the affiliated covered entity participants for treatment and other purposes as allowed by HIPAA and applicable law.

NOTICE OF SHARED RECORD

As affiliated covered entities, the participants may share records to support information sharing and operations as allowed by HIPAA and applicable law.

NOTICE OF ORGANIZED HEALTH CARE (OHCA) ARRANGEMENT

Sanford Health Plan, Security Health Plan, Sanford Health, Marshfield Clinic Health System, and The Evangelical Lutheran Good Samaritan Society participate in an Organized Health Care Arrangement (OHCA) under the Health Insurance Portability and Accountability Act (HIPAA). This OHCA allows the participating entities to share information about members and patients to promote the joint operations allowed under HIPAA related to treatment, payment, and health care operations.

CHANGES TO THIS NOTICE

We may change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request and online at www.sanfordhealthplan.com and www.securityhealth.org.

EFFECTIVE DATE
This Notice of Privacy Practices is effective October 24, 2025

Section 1 Enrollment

1.1 WHEN TO ENROLL

ADDED NEW TRUE COUNTIES THROUGHOUT THE DOCUMENT ***(FOR TRUE PLANS ONLY)***

An individual must reside within the South Dakota Counties of Minnehaha, Lincoln, Clay, Turner, Union, or Brown to be an Eligible Group Member under this Certificate of Coverage. An Eligible Group Member must reside in one of the listed counties for the duration of their Plan Year for services to be covered.

Section 3 Covered Services Overview

3.1.29 PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES

MODIFIED

Outpatient rehabilitative therapies directed at improving physical functioning of the Member, which are expected to provide significant improvement within two (2) months, as certified on a prospective basis. Services must be provided in accordance with a prescribed plan of treatment ordered by a Practitioner and/or Provider. Benefits are not available for Maintenance Care. Coverage includes:

- Physical Therapy
    - Limited to 30 visits per therapy (condition) per calendar year. Additional rehabilitative therapy visits may be allowed with Prior Authorization.
- Occupational Therapy
    - Limited to 30 visits per therapy (condition) per calendar year. Additional rehabilitative therapy visits may be allowed with Prior Authorization.
- Speech Therapy
    - Speech therapy services must be related to a specific illness, injury, or impairment, and involve the mechanics of phonation, articulation, or swallowing. Services must be provided by a licensed or certified speech pathologist.
    - Limited to 30 visits per therapy (condition) per calendar year. Additional rehabilitative therapy visits may be allowed with Prior Authorization.
- Habilitative Therapy,
    - Includes the management of limitations and disabilities and services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function.
    - Limited to 30 visits per therapy (condition) per calendar year.
- Includes One-to-one water therapy
- Physical therapy and Vitamin D supplements with a prescription order are covered at 100% (no cost) for Members ages 65 and older who are at increased risk for falls. Benefits are subject to Medical Necessity.

3.3.3 EMERGENCY OUTSIDE OUR SERVICE AREA

MODIFIED

If an Urgent Care Situation occurs when traveling outside of the Service Area, Members should contact their Primary Care Practitioner and/or Provider immediately, if one has been selected, and follow his or her instructions. If a Primary Care Practitioner and/or Provider has not been selected, the Member should contact us and follow our instructions. Coverage will be provided for Urgent Care Situations outside the Service Area at the Out-of-Network level.

NOTE: Unless care is received from an In-Network Participating Practitioner and/or Provider, coverage will be at the Out-of-Network benefit level for non-Emergency Medical Conditions or non-urgent care received when a Member is traveling or studying outside the Service Area.

NOTE: There is no coverage for care received from a Non-Participating or Out-of-Network Provider outside of the Service Area, except in the case of an Emergency Medical Condition.

Section 4 Limited and Non-Covered Services

4.1 GENERAL MEDICAL EXCLUSIONS

MODIFIED

- Elective extraction of wisdom teeth

ADDED

- Enclosure beds (e.g., Cubby Bed, SleepSafe Bed, Posey Bed, Vail Enclosure Bed)

4.2 GENERAL PHARMACY EXCLUSIONS

ADDED

5. Drugs approved under the Federal Food and Drug Administration (FDA) Accelerated Approval Program, unless medically necessary or required by law.

Section 6 Coordination of Benefits

6.7 COORDINATION OF BENEFITS WITH MEDICARE

MODIFIED

Sanford Health Plan will coordinate with Medicare in accordance with applicable federal regulations. When Medicare is primary, Sanford Health Plan pays secondary based on allowable expenses. When Sanford Health Plan is primary, Sanford Health Plan pays as usual and the Member may submit the balance to Medicare, if applicable.

Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, Sanford Health Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether the person was enrolled under any of these parts. Sanford Health Plan reserves the right to coordinate benefits with respect to Medicare Part D. Sanford Health Plan will make this determination based on the information available through CMS.

Section 11 Definitions or Terms We Use in this Certificate of Coverage

ADDED OR MODIFIED USE OF TERM(S) THROUGHOUT DOCUMENT	
Emergency Medical Condition or Situation	Sudden and unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.

In-Network Coverage	In-Network Coverage means Covered Services that are received either:
	• From an In-Network Participating Practitioner and/or Provider within the Service Area; or
	• From a Participating Provider outside of the Service Area if an In-Network Participating Practitioner and/or Provider has recommended the referral, and
	  o Sanford Health Plan has authorized the referral to a Participating Provider outside of the Service Area or
	  o Sanford Health Plan has authorized the referral from an In-Network Participating Practitioner and/or Provider to a Non-Participating Provider or Out-of-Network Participating Provider; or
	• When experiencing an Emergency Medical Condition or Situation; or
	• When the Member does not have appropriate access to In-Network Participating Practitioner and/or Provider.

Urgent Care Situation	A health condition that requires prompt medical attention to prevent worsening or complications but does not meet the criteria for Emergency Medical Condition or Situation. Failure to provide care within a reasonable time (generally within 24 hours) could result in increased discomfort or need for more extensive treatment but would not place the person's health in serious jeopardy.

All other terms and provisions of your Certificate of Coverage, including any amendments we may have previously issued, remain unaltered and in effect.

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Summary Notice

Introduction

HOW TO CONTACT SANFORD HEALTH PLAN

UPDATED PHYSICAL ADDRESS

Method	Sanford Health Plan Contact Information
PHYSICAL ADDRESS	Sanford Health Plan 4800 W 57th St. Sioux Falls, SD 57108

Section 2 How You Get Care

2.4 APPROPRIATE ACCESS

ADDED

Sanford Health Plan reserves the right to review each individual's unique situation on a case-by-case basis to evaluate factors such as access to care, medical conditions, and geographic situations to determine if an Out-of-Network or Non-Participating Provider qualifies to be covered at an In-Network coverage level.

2.14 ONGOING (CONCURRENT) PREAUTHORIZATION REQUESTS (CERTIFICATION) OF HEALTH CARE SERVICES

MODIFIED

Prior Authorization (Certification) of Inpatient health care stays will terminate on the date the Member is to be discharged from the Hospital or Facility (as ordered by the attending Physician) or when the Member's coverage is terminated.

Section 3 Covered Services Overview

3.1.26 PHYSICAL, SPEECH AND OCCUPATIONAL THERAPIES

MODIFIED

- Physical Therapy; limited to 30 visits per therapy (condition) per calendar year. Additional visits may be allowed with Prior Authorization.
- Occupational Therapy; limited to 30 visits per therapy (condition) per calendar year. Additional visits may be allowed with Prior Authorization.
- Speech Therapy; limited to 30 visits per therapy (condition) per calendar year. Additional visits may be allowed with Prior Authorization.

Section 4 Limited and Non-Covered Services

MODIFIED

- Cosmetic Services and/or supplies to repair or reshape a body structure not Medically Necessary and/or primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, cosmetic dental services, body contouring procedures, and body lifting procedures with the exception of WHCRA for coverage related to breast cancer
- Dental appliances of any sort, including but not limited to those related to Sleep Apnea (except mandibular advancement devices (MADs)), bridges, braces, and retainers that are for cosmetic reasons and/or medically necessary

Section 6 Coordination of Benefits

6.8 MEMBERS WITH END STATE RENAL DISEASE (ESRD)

MODIFIED

How Primary vs. Secondary is Determined:
The Plan will pay first for thirty (30) months after the Member becomes eligible to join Medicare, starting with the first dialysis month or transplant month. This applies regardless of employment status and includes COBRA or retirement plan coverage. After the 30-month coordination period where the Member should enroll in Medicare, Medicare is the primary payer for a Member's claims under ESRD.

Section 8 How Coverage Ends

8.4 CONTINUATION OF COVERAGE FOR CONFINED MEMBERS

REMOVED

Any Member who is an inpatient in a Hospital or other Facility on the date of coverage termination under this Benefit Plan will be covered in accordance with the terms of this Certificate until they are discharged from such Hospital or other Facility. Applicable charges for coverage that was in effect prior to termination of this Certificate will apply.

Section 9 Options After Coverage Ends

9.1 FEDERAL CONTINUATION OF COVERAGE PROVISIONS ("COBRA")

MODIFIED

Introduction
You're getting this notice because you recently gained coverage under a group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator (your Employer).

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage

through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What is COBRA continuation coverage?
COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring coverage under the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA continuation coverage available?
The employer is responsible for the timely mailing of applicable COBRA notices to Members (the "COBRA Notification Letter"). The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify the COBRA Administrator of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

How is COBRA continuation coverage provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA

continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.

Second qualifying event extension of 18-month period of continuation coverage
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any dependent children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the dependent child stops being eligible under the Plan as a dependent child. This extension is only available if the second qualifying event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?
Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at **www.healthcare.gov**.

If you have questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit **www.dol.gov/ebsa**. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit **www.HealthCare.gov**.

Keep your Plan informed of address changes
To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan contact information
Contact your employer.

Section 11 Definitions or Terms We Use in this Certificate of Coverage

MODIFIED

Natural teeth	Original teeth, which are whole, without impairment, and are not in need of the treatment provided for reasons other than dental injury; does not include prosthetic teeth, dentures, implants, or bridges.

All other terms and provisions of your Certificate of Coverage, including any amendments we may have previously issued, remain unaltered and in effect.

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Summary Notice

Section 3 Covered Services Overview

3.1 HEALTHCARE SERVICES PROVIDED BY PRACTITIONERS AND PROVIDERS

3.1.11 FAMILY PLANNING BENEFITS

2023	2024
1. Consultations and pre-pregnancy planning. 2. Member education and counseling, as prescribed by a health care provider for women with reproductive capacity. 3. Voluntary Sterilizations, including tubal ligations and vasectomies. Applicable cost sharing may apply; see contraceptive coverage covered without cost-sharing below. 4. Folic acid supplements are covered at 100% (no cost) for women planning to become pregnant or in their childbearing years.	1. Consultations and pre-pregnancy planning. 2. Member education and counseling, as prescribed by a health care provider for women with reproductive capacity. 3. Voluntary Sterilizations, including tubal ligations and vasectomies. Applicable cost sharing may apply; see contraceptive coverage covered without cost-sharing below. 4. Folic acid supplements are covered at 100% (no cost) for women planning to become pregnant or in their childbearing years. 5. Prescription contraceptives are covered up to a 12-month supply as prescribed by a Practitioner and/or Provider.

3.2 SERVICES PROVIDED BY HOSPITAL OR OTHER FACILITY

3.2.4 ORAL AND MAXILLOFACIAL SURGERY

2023	2024
• Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.* o is a child age five (5) or older- (Certification is not required for children under 5); or o is severely disabled or otherwise suffers from a developmental disability; or o has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.	• Anesthesia and Hospitalization charges for dental care that are charged as an Outpatient Services requires Certification (Prior Authorization) if a member: o is a child age fourteen (14) or older- (Certification is not required for children under 14); or o is severely disabled or otherwise suffers from a developmental disability; or o has a medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

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SANFORD HEALTH PLAN

3.3 EMERGENCY SERVICES/ACCIDENTS

3.3.1 BENEFIT DESCRIPTION

2023	2024
We cover worldwide emergency services necessary to screen and stabilize Members without Certification in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed.	We cover worldwide emergency services necessary to screen and stabilize Members without Certification in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. To be eligible for benefits after the screening and stabilization of an Emergency Medical Condition or Urgent Care Situation, follow-up care or scheduled care must be received from an In-Network Participating Practitioner and/or Provider.

3.3.3 EMERGENCY SERVICES OUTSIDE OUR SERVICE AREA

2023	2024
Added for 2024	NOTE: There is no coverage for care received from a Non-Participating or Out-of-Network Provider outside of the Service Area, except in the case of an Emergency Medical Condition or Urgent Care Situation.

3.6 DENTAL BENEFITS

3.6.1 BENEFIT DESCRIPTION

2023	2024
• Anesthesia and Hospitalization charges for dental care are covered for a Member who: This is an Outpatient Service that requires Certification. o is a child under age five (5); or o is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician; or o has a medical condition(s) as determined by a licensed Physician that places the Member at serious risk.	• Anesthesia and Hospitalization charges for dental care that are charged as an Outpatient Services requires Certification (Prior Authorization) if a member: o is a child age fourteen (14) or older- (Certification is not required for children under 14); or o is severely disabled or otherwise suffers from a developmental disability; or o has a medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

Amendment to Your Health Benefits Under Your South Dakota TRUE Certificate of Coverage

PO Box 91110
Sioux Falls, SD 57109
Toll-free: (800) 752-5863
TTY/TDD: 711*(toll free)*
sanfordhealthplan.com

SANFORD HEALTH PLAN

Section 4 Limited and Non-Covered Services

4.1 GENERAL MEDICAL EXCLUSIONS

2023	2024
Any services or supplies for the treatment of obesity that do not meet Sanford Health Plan's coverage guidelines, including but not limited to: dietary regimen (except as related to covered nutritional counseling); nutritional supplements or food supplements; and weight loss or exercise programs	Any services or supplies for the treatment of obesity (not including bariatric surgery) that do not meet Sanford Health Plan's coverage guidelines, including but not limited to: dietary regimen (except as related to covered nutritional counseling); nutritional supplements or food supplements; and weight loss or exercise programs
Dialysis services received by Non-Participating Providers when traveling out of the service area	Removed for 2024
Personal comfort items (telephone, television, guest meals and beds)	Personal comfort items (telephone, television, guest meals and guest beds)
Therapies considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: auditory integration therapy, biofeedback, chelation therapy, hippotherapy, and hyperbaric oxygen therapy.	Therapies considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: auditory integration therapy, biofeedback, chelation therapy, hippotherapy, equestrian therapy, and hyperbaric oxygen therapy
Treatment received outside of the United States	Treatment received outside the Service Area, other than during an Emergency Medical Condition or Urgent Care Situation, if a Member travels out of the Service Area for the purpose of seeking medical treatment, unless care is received from an In-Network Participating Practitioner and/or Provider

Section 6 Coordination of Benefits

6.7 COORDINATION OF BENEFITS WITH MEDICARE

2023	2024
When MSP Rules Apply to COB Medicare Coordination of Benefits provisions apply when a Member has health coverage under this Certificate of Coverage and is eligible for insurance under Medicare, Parts A and B, (whether or not the Member has applied or is enrolled in Medicare). This provision applies before any other Coordination of Benefits Provision of this Certificate of Coverage.	**When MSP Rules Apply to COB** Medicare Coordination of Benefits provisions apply when a Member has health coverage under this Certificate of Coverage and is enrolled under Medicare, Parts A and B, (whether or not the Member has applied or is enrolled in Medicare). This provision applies before any other Coordination of Benefits Provision of this Certificate of Coverage.

Amendment to Your Health Benefits Under Your South Dakota TRUE Certificate of Coverage

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SANFORD HEALTH PLAN

Section 11 Definitions of Terms We Use in this Certificate of Coverage

2023	2024
Added for 2024	Ancillary services - are services that physicians may request to help diagnose or treat a patient. Ancillary services generally fall into the categories of: • Diagnostic: assist the physician or healthcare provider in diagnosing or detecting an illness or medical condition (e.g., audiology, radiology, clinical laboratory services, pulmonary testing services). • Therapeutic: help to improve the health and well-being of the patient (e.g., speech therapy, physical therapy, occupational therapy, psychotherapy).

All other terms and provisions of your Certificate of Coverage, including any amendments we may have previously issued, remain unaltered and in effect.

Amendment to Your Health Benefits
South Dakota Large Group

PO Box 91110
Sioux Falls, SD 57109
Toll-free: (800) 752-5863
TTY/TDD: 711*(toll free)*
sanfordhealthplan.com

SANFORD HEALTH PLAN

This Amendment is effective January 1, 2023, and applies to coverage for the South Dakota Commercial, PLUS, and TRUE Certificates of Coverage. Please review this document carefully and keep it with your Certificate of Coverage for future reference.

Help understanding this document is free.
If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 752-5863 *(toll-free)* | TTY/TDD: 711 *(toll-free)*.

Help in a language other than English is also free.
Please call (800) 752-5863 *(toll-free)* to connect with us using free translation services.

Summary Notice

Free Help in Other Languages

For help in any language other than English, call 800-752-5863 (TTY: 711). Both oral and written translation services are available for free in at least 150 languages.

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 አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ 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 - ဟသူဉ်ဟသး– နမ့ါကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့ါ 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 (ATS: 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).

Introduction

HOW TO CONTACT SANFORD HEALTH PLAN

This contact information amends any contact information references throughout the document.

Method	Sanford Health Plan Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com or www.sanfordhealthplan.com/memberlogin
TRANSLATION SERVICES	(800) 752-5863
WRITE	Sanford Health Plan PO Box 91110 Sioux Falls, SD 57109-1110
PHYSICAL ADDRESS	Sanford Health Plan 300 N Cherapa Place Suite 201 Sioux Falls, SD 57103

How to contact Customer Service
For assistance with claim inquiries/status, eligibility and enrollment, provider access, and order ID cards, please call or write to Customer Service. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Customer Service Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
FAX	(605) 328-6812
HOURS	7:30 a.m. to 5 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com
WRITE	Sanford Health Plan Customer Service PO Box 91110 Sioux Falls, SD 57109-1110

How to contact us with questions about Certification (prior authorization)
Some of the services listed in this document are covered only if your doctor or other network provider gets approval in advance (called Certification or prior authorization) from us. The Utilization Management department handles all certification requests. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Utilization Management Contact Information
CALL	(800) 805-7938 *calls to this number are free*
TTY	711
FAX	(605) 328-6813
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Utilization Management PO Box 91110 Sioux Falls, SD 57109-1110

How to contact Pharmacy Management
For assistance with pharmacy benefit questions, formularies, or drug pre-authorization, please call or write to Pharmacy Management.

Method	Pharmacy Management Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
FAX	(701) 234-4568
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Pharmacy Management PO Box 91110 Sioux Falls, SD 57109-1110

How to contact Appeals and Grievances *(formerly referenced as Appeals and Complaints)*
For assistance with Complaints (grievances) and appeal rights, contact the Appeals and Grievances department. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Appeals and Grievances Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Appeals and Grievances Department PO Box 91110 Sioux Falls, SD 57109-1110

Members may file a request for Adverse Determinations of Prospective (Pre-service) or Retrospective (Post-service) Review with Sanford Health Plan or with the South Dakota Division of Insurance. Refer to Section 10 PROBLEM RESOLUTION for more information.

Members have the right to contact the South Dakota Division of Insurance at any time.

Method	South Dakota Division of Insurance Contact Information
CALL	(605) 773-3563
FAX	(605) 773-5369
WRITE	South Dakota Department of Revenue & Regulation Division of Insurance 124 South Euclid Avenue, 2nd Floor Pierre, SD 57501

NOTICE OF NON-DISCRIMINATION

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 shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew a Certificate of Coverage, (b) terminate coverage, (c) limit benefits, or (d) charge a different Service Charge.
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, contact Sanford Health Plan at (800) 752-5863.

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, you can file a grievance by contacting the Section 504 Coordinator.
Section 504 Coordinator
2301 E. 60th Street
Sioux Falls, SD 57104
Phone: (877) 473-0911 | TTY: 711
Fax: (605) 312-9886
Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by mail, fax, phone, 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Section 1 Enrollment

1.5 ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

Dependent Child

Be one of the following:

2. under thirty (30) years old and enrolled in and attending an accredited college, university, or trade or secondary school on a full-time basis (coverage extends through the month they turn thirty (30) years old). For the purpose of the Plan, the school's definition of "full-time student" shall be used to determine if a Dependent is a full-time student;

Section 3 Covered Services

3.1 HEALTH SERVICES PROVIDED BY PRACTITIONERS AND PROVIDERS

3.1.6 DIABETES SUPPLIES, EQUIPMENT AND EDUCATION BENEFITS

ITEM (* CERTIFICATION REQUIRED)	MUST BE OBTAINED AT:	BENEFIT/COST INFORMATION
• Blood Glucose test strips • Glucagon • Glucometers • Glucose Agents • Lancets and lancet devices • Prescribed oral agents for controlling blood sugars • Syringes • Urine testing strips	Pharmacy (prescription required)	Pharmacy Benefit Depending on plan, copay or deductible/coinsurance may apply
• Custom diabetic shoes and inserts limited to one (1) pair of depth- inlay shoes and three (3) pairs of inserts; or one (1) pair of custom molded shoes (including inserts) and three (3) additional pairs of inserts	Durable Medical Provider	Medical Benefit Deductible/coinsurance will apply
• Continuous Glucose Monitor Receiver*	Durable Medical Provider and or Pharmacy (prescription required)	Pharmacy Benefit (must be on formulary and available through a pharmacy) Medical Benefit (if obtained through a Durable Medical Provider) Depending on plan, copay or deductible/coinsurance may apply
• Insulin Pump*	Durable Medical Provider and or Pharmacy (prescription required)	Medical Benefit Deductible/coinsurance will apply

3.1.12 FOOT CARE SERVICES

Routine foot care covered for Members when medically appropriate.

3.1.13 HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES)

Exams and Services	Child	Adult
Routine hearing examination	Covered for ages 0-21 as outlined in Sanford Health Plan Preventive Health Guidelines	Not covered
Emergency and acute hearing services	Covered	Covered
Diagnosis and treatment of sudden sensorineural hearing loss (SSNHL)	Covered	Covered

* The provision of hearing aids must meet criteria for rehabilitative and/or habilitative services coverage and either:
  - provide significant improvement to the Member within two (2) months, as certified on a prospective and timely basis by Sanford Health Plan; or
  - help maintain or prevent deterioration in physical, cognitive, or behavioral function.

3.1.27 PRENATAL AND MATERNITY SERVICES

Breastfeeding support, supplies and counseling are covered in the following manner:

- Sanford Health Plan will allow one breast pump (electric or manual) per pregnancy.
- Breast pump replacement supplies, including tubing, adapters, locking rings, breast shields, splash protectors, and breast pump bottles and caps, are covered.
- Breast milk storage bags are covered.
- Bottles which are not specific to breast pump operation and all associated supplies are NOT covered.
- Pumps and supplies are covered only when obtained from a Sanford Health Plan In-Network Participating Practitioner and/or Provider. This does NOT include drugstores or department stores.

3.1.30 SERVICES FOR TRANSGENDER PEOPLE

Sanford Health Plan shall cover transgender services related to the treatment of gender dysphoria, including surgical, non-surgical, and gender-specific preventive services, when deemed medically appropriate and necessary by a qualified health professional. Coverage does not include certain ancillary services, nor does it include cosmetic services such as facial feminization/masculinization surgery. Sanford Health Plan does not cover conversion therapy.

Determination of medical necessity and prior authorization protocol is based on the most recent, published medical standards set forth by nationally recognized medical experts in the transgender health field. For transgender coverage determination, Sanford Health Plan adheres to the World Professional Association for Transgender Health (WPATH) Standards of Care, which present evidence based clinical eligibility and readiness criteria for transition-related treatment. Clinical care guidelines are referenced during medical necessity reviews so that coverage is provided consistently and appropriately.

Prior authorization is required. Failure to obtain prior authorization may result in a reduction or denial of benefits.

3.4 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

3.4.2 APPLIED BEHAVIOR ANALYSIS FOR TREATMENT OF AUTISM SPECTRUM DISORDER

5. Limits are subject to the Plan's medical management policies and determinations of Medical Necessity.

3.5 OUTPATIENT PRESCRIPTION DRUG BENEFITS

BENEFIT DESCRIPTION

ADDED

- There are no limitations or restrictions for use of manufacturer coupons if used in conjunction with our benefit offering

Section 4 Limited and Non-Covered Services

ADDED OR MODIFIED

- All other hearing related supplies, purchases, examinations, testing or fittings not covered under this policy
- Certain ancillary services
- Conversion therapy
- Cosmetic services such as facial feminization/masculinization surgery; including but not limited to including but not limited to liposuction, lipofilling, voice modification therapy/surgery, trachea shave/thyroid chondroplasty, gluteal augmentation, hair removal, pectoral implants, or other aesthetic procedures
- Dietary surveillance and counseling, unless part of a wellness visit
- Elective abortion services except when the mother's life is endangered. Prior Authorization/certification required
- Service call charges and charges for repair estimates
- Services not medically appropriate to do via telehealth
- Tests considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: allergy testing, celiac antibody testing, hair analysis, testing for mitochondrial disorders, and micronutrient testing
- Therabands and cervical pillows
- Therapies considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: auditory integration therapy, biofeedback, chelation therapy, hippotherapy, and hyperbaric oxygen therapy
- Treatment of weak, strained, or flat feet
- Weight loss or exercise programs or equipment that do not meet the Plan's Medical Necessity coverage guidelines

REMOVED

- Behavioral therapy, modification, or training
- Compact (portable) travel hemodialyzer system
- Education and training for patient self management by a qualified, non physician health care professional using standardized curriculum, face to face with the patient could include caregiver/family
- Hearing aids for the treatment of gradual hearing loss that occurs with aging and/or other lifestyle factors, non-implant devices, or equipment to correct hearing impairment or loss
- Hemodialysis machine (not separately payable)
- Incidental cholecystectomy performed at the time of weight loss surgery
- Male condoms
- Treatment of gradual deterioration of hearing that occurs with aging and/or other lifestyle factors, and related adult hearing screening services, testing and supplies
- Unspecified complication of kidney transplant
- Virtual colonoscopies

Section 9 Options After Coverage Ends

9.1 FEDERAL CONTINUATION OF COVERAGE PROVISIONS ("COBRA")

When is COBRA Coverage Available

The employer is responsible for the timely mailing of applicable COBRA notices to Members (the "COBRA Notification Letter"). If your employer has elected to administer COBRA through Sanford Health Plan, it is important to know Sanford Health Plan administers COBRA through WEX. The employer must notify WEX when qualifying events occur. WEX will offer COBRA continuation coverage to qualified beneficiaries only after being notified by the employer that a qualifying event has occurred. The employer must notify WEX of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For other qualifying events (such as divorce or legal separation of the employee and Spouse or a child losing eligibility for coverage as a Dependent Child), you must notify WEX.

How is COBRA Coverage Elected?

• If Sanford Health Plan is administering your COBRA coverage, the employer must notify WEX of the changes. The employee will receive an election notice form by mail to elect continuation coverage. The election period to request a continuation of coverage will expire sixty (60) days from the date of the Member's election notice.

If Sanford Health Plan is administering your COBRA coverage: Your first COBRA premium payment, and all premium payments should be sent to: WEX COBRA Payments/Forms, PO Box 2079, Omaha, NE 68103-2079.

COBRA Contact Information

Mail Payments: COBRA Payments / Forms, PO Box 2079, Omaha, NE 68103-2079
Phone: (866) 451-3399
Fax: (888) 408-7224
Email: cobraadmin@wexhealth.com

Section 11 Definitions or Terms We Use in this Certificate of Coverage

Cosmetic	Surgery, medication, or other services performed for the primary purpose of enhancing or altering physical appearance without correcting, restoring or improving physiological function, or improving an underlying condition or disease.
Encounter	Any type of initiated contact between a member and provider via a qualified telehealth technology platform.

All other terms and provisions of your Certificate of Coverage, including any amendments we may have previously issued, remain unaltered and in effect.

Amendment to Your Health Benefits Under Your South Dakota Commercial Certificate of Coverage

PO Box 91110
Sioux Falls, SD 57109
Toll-free: (800) 752-5863
TTY/TDD: 711 *(toll free)*
sanfordhealthplan.com

SANFORD HEALTH PLAN

This Amendment is effective January 1, 2022, and applies to the South Dakota TRUE Commercial Certificate of Coverage. Please review this document carefully, and keep it with your Certificate of Coverage for future reference.

Help understanding this document is free.

If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 752-5863 *(toll-free)* | TTY/TDD: 711 *(toll-free)*.

Help in a language other than English is also free.

Please call (800) 752-5863 *(toll-free)* to connect with us using free translation services.

Summary Notice

Free Help in Other Languages

For assistance in a language other than English, call 1-800-752-5863 (toll-free) | TTY/TDD 711.

Notice of Privacy Practices

This Notice of Privacy Practices ("Notice") applies to Sanford Health Plan including Align powered by Sanford Health Plan and Great Plains Medicare Advantage. If you have questions about this Notice, please contact Customer Service at (800) 752-5863 *(toll-free)* | TTY/TDD 711 (toll-free).

This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by Sanford Health Plan, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a Member under a policy or contract, or a prospective Member, obtained by Sanford Health Plan from that person or from a health care Provider, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form, is confidential and may not be disclosed to any person except as set forth below.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We use or disclose your health information as follows (In Minnesota we will obtain your prior consent):

- **Help manage the health care treatment you receive:** We can use your health information and share it with professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional services.
- **Pay for your health services:** We can use and disclose your health information as we pay for your health services. For example, we share information about you with your Primary Care Practitioner and/or Provider to coordinate payment for those services.
- **For our health care operations:** We may use and share your health information for our day-to-day operations, to improve our services, and contact you when necessary. For example, we use health information about you to develop better services for you. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.
- **Administer your coverage:** We may disclose your health information to your health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the Premiums we charge.

We may share your health information in the following situations unless you tell us otherwise. If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest or needed to lessen a serious and imminent threat to health or safety:

- **Friends and Family:** We may disclose to your family and close personal friends any health information directly related to that person's involvement in payment for your care.

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Sioux Falls, SD 57109
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SANFORD HEALTH PLAN

- **Disaster Relief:** We may disclose your health information to disaster relief organizations in an emergency.

We may also use and share your health information for other reasons without your prior consent:

- **When required by law:** We will share information about you if state or federal law require it, including with the Department of Health and Human services if it wants to see that we're complying with federal privacy law.
- **For public health and safety:** We can share information in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone's health or safety.
- **Organ and tissue donation:** We can share information about you with organ procurement organizations.
- **Medical examiner or funeral director:** We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- **Worker's compensation and other government requests:** We can share information to employers for worker's compensation claims. Information may also be shared with health oversight agencies when authorized by law, and other special government functions such as military, national security and presidential protective services.
- **Law enforcement:** We may share information for law enforcement purposes. This includes sharing information to help locate a suspect, fugitive, missing person or witness.
- **Lawsuits and legal actions:** We may share information about you in response to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for certain research projects that have been evaluated and approved through a process that considers a Member's need for privacy.

We may contact you in the following situations:

- **Treatment options:** To provide information about treatment alternatives or other health related benefits or Sanford Health Plan services that may be of interest to you.
- **Fundraising:** We may contact you about fundraising activities, but you can tell us not to contact you again.

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION

When it comes to your health information, you have certain rights.

- **Get a copy of your health and claims records:** You can ask to see or get a paper or electronic copy of your health and claims records and other health information we have about you. We will provide a copy or summary to you usually within *thirty* (30) days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your health and claims records:** You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we'll tell you why in writing. These requests should be submitted in writing to the contact listed below.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be approved. We must say "yes" if you tell us you would be in danger if we do not.
- **Ask us to limit what we use or share:** You can ask us to restrict how we share your health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for *six* (6) years prior, who we've shared it with, and why. We will include all disclosures except for those about your treatment, payment, and our health care operations, and certain other disclosures (such as those you asked us to make). We will provide *one* (1) accounting a year for free, but we will charge a reasonable cost-based fee if you ask for another within *twelve* (12) months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

PO Box 91110
Sioux Falls, SD 57109
Toll-free: (800) 752-5863
TTY/TDD: 711 *(toll free)*
sanfordhealthplan.com

SANFORD HEALTH PLAN

- **File a complaint if you feel your rights are violated:** You can complain to the U.S. Department of Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.

Contact Information
Sanford Health Plan
Customer Service
PO Box 91110
Sioux Falls, SD 57109-1110
(800) 752-5863 *(toll-free)* | TTY/TDD 711

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

- We are required by law to maintain the privacy and security of your health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this Notice and offer to give you a copy.
- We will not use, share, or sell your information for marketing or any purpose other than as described in this Notice unless you tell us to in writing. You may change your mind at any time by letting us know in writing.

CHANGES TO THIS NOTICE
We may change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request and online at www.sanfordhealthplan.com.

EFFECTIVE DATE
This Notice of Privacy Practices is effective February 1, 2022.

NOTICE OF AFFILIATED COVERED ENTITY DESIGNATIONS
Sanford Health Plan, Sanford Health, and The Evangelical Lutheran Good Samaritan Society, as covered entities under common ownership and control, have designated themselves and subsidiaries as a single covered entity for purposes of the Health Insurance Portability and Accountability Act (HIPAA). Sanford Health Plan shares health information about its members with the affiliated covered entity participants for treatment and other purposes as allowed by HIPAA and applicable law.

Introduction

Service Area

The Service Area for **IOWA** includes the following counties

Clay	Emmet	Lyon	Osceola	Plymouth
Dickinson	Ida	O'Brien	Sioux	Woodbury

The Service Area for **MINNESOTA** includes the following counties

Becker	Clay	Jackson	Lake of the Woods	Martin	Nobles	Polk	Rock	Swift
Beltrami	Clearwater	Kandiyohi	Lincoln	McLeod	Norman	Pope	Roseau	Traverse
Big Stone	Cottonwood	Kittson	Lyon	Meeker	Otter Tail	Red Lake	Sibley	Wilkin
Blue Earth	Douglas	Lac Qui	Mahnomen	Murray	Pennington	Redwood	Stearns	Watonwan
Brown	Grant	Parle	Marshall	Nicollet	Pipestone	Renville	Stevens	Yellow Medicine
Chippewa	Hubbard							

Section 3.1 Covered Services

3.1.17 LAB, X-RAY AND OTHER DIAGNOSTIC TESTS

- **NOTE:** Some of these services fall under High End Imaging and may require Certification. Failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

3.1.21 ORTHOTIC AND PROSTHETIC DEVICES

- Limit of *twelve (12)* Prosthetic Socks per year per limb

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3.1.30 TELEHEALTH SERVICES (VIRTUAL VISITS)

Services for telehealth are covered when the following conditions are met:

- The encounter involves a qualifying CPT code that the Health Plan has approved to be conducted by telehealth.
- The services are medically necessary and meet the definition of Covered Health Services as described in this Plan document.
- The technology platform used for the encounter is HIPAA compliant.
- The technology platform used for the encounter allows for fully synchronous, real-time, audio-video connection between the patient and the provider for the duration of the encounter.
- If the patient is physically present with one provider (host location) and is being connected to a remote (distant) provider, charges by the host provider as an originating site to facilitate the connection with the distant provider performing the service are also eligible for coverage, as well as the qualifying charges from the distant provider for conducting the telehealth encounter.

These services shall be available only when services are provided by Participating Providers. Cost share may be subject to applicable Deductible and/or Cost Sharing Amounts and vary based on platform used to complete the visit. For more information, please refer to the Virtual Care Policy at sanfordhealthplan.com.

3.5.1 BENEFIT DESCRIPTION

- Prescription refills will be covered when 75% of your prescription has been used up with a surplus limit of 10 days. The surplus limit is calculated based on the amount of medication obtained over the previous 180 days and limits you to a maximum of 10 days of additional medication at any given time.

- If you receive a brand name drug when there is a generic equivalent or biosimilar alternative available, you will be required to pay a brand penalty. The brand penalty consists of the price difference between the brand name drug and the generic equivalent or biosimilar alternative, in addition to applicable cost sharing (copay and/or deductible/coinsurance) amounts. Brand penalties do not apply to your deductible or maximum out of pocket.

3.5.3 COVERED TYPES OF PRESCRIPTIONS

- Generic contraceptives, injections and/or devices will be covered by the Plan at 100% (no charge)

Exclusions Added

- *Chemical peel for acne*
- *LASIK Eye Surgery*
- *Refractive errors of the eye*

Section 4.7 Out-of-Network Benefits

Here are some important things to keep in mind about these benefits:

- **This Certificate of Coverage does not cover any Out-of-Network services unless:**
  - There is an emergency or urgent care situation; or
  - Prior Authorization is granted (See Services requiring Certification in Section 2)

  The Member is responsible for all costs associated with Out-Of-Network Services unless the above conditions are met.

Out-of-Network Coverage means Covered Services that do not fit the definition of In-Network Coverage as set forth in Section 2.

Out-of-Network Coverage means non-emergency and/or non-urgent Covered Services that are received from the following:

- from Non-Participating Practitioners and/or Providers when Sanford Health Plan has not authorized the referral;
- from a Participating Practitioner and/or Provider that is not “In-Network” when Sanford Health Plan has not authorized the referral;
- an In-Network Participating Practitioner and/or Provider has not recommended the referral; and

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- Sanford Health Plan has not authorized the referral to a Participating Practitioner and/or Provider outside of Sanford Health Plan's Service Area.

When you obtain non-emergency medical treatment from a Non-Participating Practitioner and/or Provider or from a Participating Provider who is not In-Network, without authorization from us, you are responsible for all costs.

Section 5.3 Balance Billing from Non-Participating Providers

Balance billing, sometimes referred to as surprised billing, is the practice of a medical provider charging a patient for the difference between the total cost of services being billed and the amount the insurance pays. When a Member receives Covered Services from an In-Network Participating Practitioner and/or Provider, the Member is protected from balance billing because the provider cannot attempt to collect charges above what Sanford Health Plan reimburses. When Sanford Health Plan does not have a contractual relationship in place and the provider is a Non-Participating Provider, they may not accept Sanford Health Plan's payment arrangements and Members may be balanced billed for services received.

Members may be balance billed in emergency situations even when Sanford Health Plan covers all of the charges at an In-Network Level if the provider is a Non-Participating Provider who will not accept our payment as full and final. In such circumstances, the Non-Participating Provider must satisfy the Notice and Consent Process and Requirements before sending surprise bills. Out-of-Network facilities and providers are prohibited from sending surprise bills for out-of-network cost sharing without signed consent from the Member. Please check the Sanford Health Plan provider directory before receiving services to make sure you are seeing an In-Network Participating Practitioner and/or Provider.

If you think you've been wrongly billed, contact the No Surprises Help Desk (NSHD) at 1-800-985-3059 or visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law. For Minnesota residents, you may also contact the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602 for more information about your rights under Minnesota law.

Section 10.1 MEMBER APPEAL PROCEDURES – OVERVIEW

Maximum Appeal Timelines			
Type of Notice	**Emergency**	**Pre-Service**	**Post-Service**
Initial Determinations	24 Hours	15 days	30 Days
Extension for Initial Plan Determinations	NONE	15 days	15 Days
Additional Information Request (Plan)	24 Hours	15 days	15 Days
Response to Request For Additional Information (Member)	48 Hours	45 Days	45 Days
Request for Internal Appeal (Member)	180 Days	180 Days	180 Days
Internal Appeal Determinations	72 Hours	30 Days	60 Days
Request for External Appeal (Member)	N/A	4 months	4 Months
External Appeal Determinations	72 Hours	45 Days	45 Days

All other terms and provisions of your Certificate of Coverage, including any amendments we may have previously issued, remain unaltered and in effect.

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FREE HELP IN OTHER LANGUAGES

This Policy replaces any prior policies you may have had. We hope you find it easy to read and helpful in answering your health coverage questions. It is the legal document representing your coverage, so please keep it in a safe place where you can easily find it.

If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us toll-free at the number below.

For help in a language other than English, please call us toll-free at (800) 892-0675. Both oral and written translation services are available for free in at least 150 languages.

English
This Notice has Important Information. This notice has important information about your application or coverage through Sanford Health Plan. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-800-752-5863 (toll-free) | TTY/TDD: 1-877-652-1844 *(toll-free)*. For assistance in a language other than English, call 1-800-892-0675 (toll-free).

Spanish
Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Sanford Health Plan. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-892-0675.

German
Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Sanford Health Plan. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-892-0675.

Chinese
本通知有重要的訊息。本通知有關於您透過 插入 Sanford Health Plan 項目的名稱 Sanford Health Plan 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入數字 1-800-892-0675.

Cushite
Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Sanford Health Plan tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 1-800-892-0675 tii bilbilaa.

Vietnamese

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Sanford Health Plan. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ trúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-892-0675.

Bantu

Iyi notice ifise akamaro k'ingenzi. Iyi notice ifise akamaro kingene utegerezwa gusaba canke ivyerekeye Sanford Health Plan, ucuraba ko ibikenewe kuriyi notice, ushobora gufata umwanzuro ukungene wokurikirana ubuzima bwawe uburihiye. Kandi ukongera kugira uburenganzira bwo kwigenga kuronka amakuru n'ubufasha mu rurimi gwawe atacyo utanze. Hamagara 1-800-892-0675.

Arabic

ةماه تامولعم راعشلاا اذه يوحي.للاخ نم ةيطغتلا ىلع لوصحلل كبلط صوصخب ةمهم تامولعم راعشلاا اذه يوحي Sanford Health Plan.
راعشلاا اذه يف ةماهلا خيراوتلا نع ثحبا.عفد يف ةدعاسملل وا ةيحصلا كتيطغت ىلع ظافحلل ةنيعم خيراوت يف ءارجا ذاختلا جاتحت دق
فيلاكتلا.ةفلكت يأ نود نم كتغلب ةدعاسملاو تامولعملا ىلع روصحلا يف قحلا كل .ب لصتا 1-800-892-0675.

Swahili

Ilani hii ina Taarifa Muhimu. Ilani hii ina taarifa muhimu kuhusu maombi yako au chanjo kupitia Sanford Health Plan. Angalia kwa ajili ya tarehe muhimu katika ilani hii. Waweza pia hitajika kuchukua hatua katika muda ulio pangwa fulani ili uweze ku hifadhi bima yako ya afya au msaada wa gharama zake. Una haki ya kupata habari hii na msaada kwa lugha yako bila gharama. Piga nambari hii: 1-800-892-0675.

Russian

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Sanford Health Plan. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-800-892-0675.

Nepali

यो सूचनामा महत्त्वपूर्ु जानकारी छ । यो सूचनामा तपाईंको आवेिन वा Sanford Health Plan **का माध्यमबाट प्राप्त हुने सुदविाबारे महत्त्वपूर्ु जानकारी छ । यो सूचनामा भएका महत्त्वपूर्ु दमदतहरू ख्याल िनुुहोस् । तपाईंले पाइरहेको स्वास््य दबमा पाइरहन वा तपाईंको खचुको भुक्तानीमा सहायता पाउन केही समय-सीमामा काम-कारवाही िनुुपने हुनसक्छ । तपाईंले यो जानकारी र सहायता आफ्नो मातृभाषामा दन:शुल्क पाउनु तपाईंको अदिकार हो ।** 1-800-892-0675 **मा फोन िनुुहोस् ।**

Japanese

この通知には重要な情報が含まれています。この通知には、 Sanford Health Plan の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1-800-892-0675 までお電話ください。

French
Cet avis a d'importantes informatio
ns. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Sanford Health Plan. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-800-892-0675.

Korean
본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Sanford Health Plan 을 통한 커버리지 에 관한 정보를 포함하고 있습니다.
본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-892-0675 로 전화하십시오.

Tagalog
Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Sanford Health Plan. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-892-0675.

Norwegian
Denne kunngjøringen har viktig informasjon. Kunngjøringen inneholder viktig informasjon om programmet eller dekning gjennom Sanford Health Plan. Se etter viktige datoer i denne kunngjøringen. Du må kanskje ta affære ved visse frister for å beholde helsedekning eller økonomisk bistand. Du har rett til å få denne informasjonen og hjelp i ditt språk uten kostnad. Ring 1-800-892-0675.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to Sanford Health Plan. If you have questions about this Notice, please contact Customer Service at (800) 752-5863 *(toll-free)* | TTY/TDD (877) 652-1844 *(toll-free)*.

This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by Sanford Health Plan, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We use or disclose your health information as follows (In Minnesota we will obtain your prior consent):

- Help manage the health care treatment you receive: We can use your health information and share it with professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional services.
- Pay for your health services: We can use and disclose your health information as we pay for your health services. For example, we share information about you with your Primary Care Practitioner to coordinate payment for those services.
- For our health care operations: We may use and share your health information for our day-to-day operations, to improve our services, and contact you when necessary. For example, we use health information about you to develop better services for you. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage.
- Administer your coverage: We may disclose your health information to your health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the Premiums we charge.

We may share your health information in the following situations unless you tell us otherwise. If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest or needed to lessen a serious and imminent threat to health or safety:

- Friends and Family: We may disclose to your family and close personal friends any health information directly related to that person's involvement in payment for your care.
- Disaster Relief: We may disclose your health information to disaster relief organizations in an emergency.
- We may also use and share your health information for other reasons without your prior consent:
- When required by law: We will share information about you if state or federal law require it, including with the Department of Health and Human services if it wants to see that we're complying with federal privacy law.
- For public health and safety: We can share information in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone's health or safety.
- Organ and tissue donation: We can share information about you with organ procurement organizations.
- Medical examiner or funeral director: We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- Worker's compensation and other government requests: We can share information to employers for Worker's compensation claims. Information may also be shared with health oversight agencies when

authorized by law, and other special government functions such as military, national security and presidential protective services.
- Law enforcement: We may share information for law enforcement purposes. This includes sharing information to help locate a suspect, fugitive, missing person or witness.
- Lawsuits and legal actions: We may share information about you in response to a court or administrative order, or in response to a subpoena.
- Research: We can use or share your information for certain research projects that have been evaluated and approved through a process that considers a Member's need for privacy.

We may contact you in the following situations:

- Treatment options: To provide information about treatment alternatives or other health related benefits or Sanford Health Plan services that may be of interest to you.
- Fundraising: We may contact you about fundraising activities, but you can tell us not to contact you again.

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION

When it comes to your health information, you have certain rights.

- Get a copy of your health and claims records: You can ask to see or get a paper or electronic copy of your health and claims records and other health information we have about you. We will provide a copy or summary to you usually within *thirty* (30) days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your health and claims records: You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we'll tell you why in writing. These requests should be submitted in writing to the contact listed below.
- Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be approved. We must say "yes" if you tell us you would be in danger if we do not.
- Ask us to limit what we use or share: You can ask us to restrict how we share your health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for *six* (6) years prior, who we've shared it with, and why. We will include all disclosures except for those about your treatment, payment, and our health care operations, and certain other disclosures (such as those you asked us to make). We will provide *one* (1) accounting a year for free, but we will charge a reasonable cost-based fee if you ask for another within *twelve* (12) months.
- Get a copy of this privacy notice: You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.

- File a complaint if you feel your rights are violated: You can complain to the U.S. Department of Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.

CONTACT INFORMATION

Sanford Health Plan
Customer Service
PO Box 91110
Sioux Falls, SD 57109-1110
(800) 752-5863 *(toll-free)* | TTY/TDD (877) 652-1844 *(toll-free)*

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

- We are required by law to maintain the privacy and security of your health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this Notice and offer to give you a copy.
- We will not use, share, or sell your information for marketing or any purpose other than as described in this Notice unless you tell us to in writing. You may change your mind at any time by letting us know in writing.

CHANGES TO THIS NOTICE

We may change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request and on our website www.sanfordhealthplan.com.

EFFECTIVE DATE

This Notice of Privacy Practices is effective January 1, 2021.

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT FOR SANFORD HEALTH PLAN

Sanford Health Plan and Sanford Health Plan of Minnesota have agreed, as permitted by law, to share your health information among themselves for the purposes of treatment, payment, or health care operations. This notice is being provided to you as a supplement to the above Notice of Privacy Practices.

INTRODUCTION

HOW TO CONTACT SANFORD HEALTH PLAN [THE "PLAN"]

Sanford Health Plan is ready to help Monday through Friday, 8:00 a.m. to 5 p.m. CST and a confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Physical Address	Sanford Health Plan 300 Cherapa Place, Suite 201 Sioux Falls, SD 57103
Mailing Address	Sanford Health Plan PO Box 91110 Sioux Falls, SD 57109-1110
Customer Service	(800) 752-5863 *(toll-free) or* TTY/TDD: (877) 652-1844 *(toll- free)*
Certification	The Hospital, your Provider, or you should call (800) 805-7938 (*toll-free)* or TTY/TDD (877) 652-1844 *(toll-free)*
Sanford Health Plan Provider/Practitioner Locator	If you need to locate a Provider in your area, call (800) 752-5863 or TTY/TDD: (877) 652-1844 *(toll-free)*
Appeals and Complaints Department	(877) 652-8544*(toll-free)* or TTY/TDD: (877) 652-1844 *(toll-free)*
Website	www.sanfordhealthplan.com
Translation Services *(free to Members)*	**(**800) 892-0675 *(toll-free)*

MEMBER RIGHTS

Sanford Health Plan is committed to treating Members in a manner that respects their rights. In this regard, Sanford Health Plan recognizes that each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) has the right to the following:

- Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; national origin; color; gender; gender identity; age; sex; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; or sources of payment for care.
- Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
- Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
- Members have the right, but are not required, to select a Primary Care Physician (PCP) of their choice. If a Member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
- Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable Minnesota law.
- Members have the right to know the identity and professional status of individuals providing service to them and to know which Physician or other Provider is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
- Members have the right to a candid discussion with the Practitioners and/or Providers responsible for coordinating appropriate or Medically Necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with Practitioners and/or Providers in decision making regarding their treatment plan.
- Members have the right to give informed consent before the start of any procedure or treatment.
- When Members do not speak or understand the predominant language of the community, Sanford Health Plan will make its best efforts to access an interpreter. Sanford Health Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
- Members have the right to receive printed materials that describe important information about Sanford Health Plan in a format that is easy to understand and easy to read.
- Members have the right to a clear Grievance and Appeal process for complaints and comments and to have their issues resolved in a timely manner.
- Members have the right to Appeal any decision regarding Medical Necessity made by Sanford Health Plan.
- Members have the right to terminate coverage, in accordance with Employer and/or Plan guidelines.

- Members have the right to make recommendations regarding Sanford Health Plan's Member's rights and responsibilities policies.
- Members have the right to receive information about Sanford Health Plan, its services, its Practitioners and Providers, and Members' rights and responsibilities.

MEMBER RESPONSIBILITIES

Each Member (or the Member's parent, legal guardian or other representative if the Member is a minor or incompetent) is responsible for cooperating with those providing Health Care Services to the Member, and shall have the following responsibilities:

- Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible Provider. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
- Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when telephoning or contacting the Plan.
- Members are responsible for following all access and availability procedures.
- Members are responsible for seeking emergency care at an In-Network Participating Practitioner and/or Provider whenever possible. In the event an ambulance is used, direct the ambulance to the nearest participating emergency Facility unless the condition is so severe that the Member must use the nearest emergency Facility. State law requires that the ambulance transport you to the Hospital of your choice unless that transport puts you at serious risk.
- Members are responsible for notifying Sanford Health Plan of an emergency admission no later than forty-eight (48) hours after becoming physically or mentally able to give notice or as soon as reasonably possible.
- Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible Practitioner or the Hospital.
- Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health conditions, including mental health and/or substance use disorders.
- Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
- Members are responsible for notifying the Group within *thirty (30)* days at (800) 752-5863 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)* of name, address, or telephone number changes.
- Members are responsible for notifying the Group of any changes of eligibility that may affect their membership or access to services. The employer is responsible for notifying Sanford Health Plan.

SERVICE AREA

The Service Area for **SOUTH DAKOTA** and **NORTH DAKOTA** includes all counties in the state.

The Service Area for **IOWA** includes the following counties

Clay	Emmet	Lyon	Osceola	Plymouth
Dickinson	Ida	O'Brien	Sioux	Woodbury

The Service Area for **MINNESOTA** includes the following counties

Becker	Clay	Lake of the	Martin	Nobles	Polk	Rock	Swift
Beltrami	Clearwater	Woods	McLeod	Norman	Pope	Roseau	Traverse
Big Stone	Cottonwood	Lincoln	Meeker	Otter Tail	Red Lake	Sibley	Wilkin
Blue Earth	Douglas	Lyon	Murray	Pennington	Redwood	Stearns	Watonwan
Brown	Grant	Mahnomen	Nicollet	Pipestone	Renville	Stevens	Yellow
Chippewa	Hubbard	Marshall					Medicine

MEDICAL TERMINOLOGY

All medical terminology referenced in this Certificate of Coverage follows the industry standard definitions of the American Medical Association.

DEFINITIONS

Capitalized terms are defined in Section 11 of this Policy.

CONFORMITY WITH STATE AND FEDERAL STATUTES

Any provision in this Policy not in conformity with South Dakota laws or rules may not be rendered invalid but be must construed and applied as if it were in full compliance with any applicable State and Federal statutes. If, on the effective date of this policy, any provision of this policy is in conflict with federal statutes, or the statutes of the State of South Dakota, then this Policy shall be considered amended to conform to the minimum requirements of such laws and regulations.

.GOVERNING LAW

To the extent not superseded by the laws of the United States, this Policy will be construed in accordance with and governed by the laws and rules of the United States of America and the state of South Dakota. Any action brought because of a claim under this Policy will be litigated in state or federal courts located in the state of South Dakota and in no other.

FRAUD

Fraud is a crime that can be prosecuted. Any Member who willfully and knowingly engages in an activity intended to defraud Sanford Health Plan is guilty of fraud.
As a Member, you must:

- File accurate claims. If someone else files claims on your behalf, you should review the form before you sign it;

- Review the Explanation of Benefits (EOB) form when it is returned to you. Make certain that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your ID card is lost, you should report the loss to Sanford Health Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

If you are uncertain or concerned about any information or charge that appears on a bill, form, or Explanation of Benefits; or if you know of, or suspect, any illegal activity, call Sanford Health Plan at (800) 752-5863. All calls are strictly confidential. In the absence of fraud, all statements made by applicants, the Group or a Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall avoid such coverage or reduce benefits unless contained in a written instrument signed by the Group or Member, a copy of which has been furnished to such Group or Member or the Member's representative.

INCONTESTABILITY

Only an act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, made by any applicant for health insurance coverage, may be used to rescind this application or Certificate of Coverage, terminate coverage and deny claims.

PHYSICAL EXAMINATION

We may have, at our own expense, a physician examine you when, and as often as we may reasonably require, during the pendency of a claim under this Policy.

CLERICAL ERROR

Any clerical error by the Group in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a reimbursement amount, Sanford Health Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Member, if it is requested, the amount of overpayment may be deducted from future benefits payable.

AMENDING AND TERMINATING THIS CONTRACT

If this Contract is terminated, the rights of the Members are limited to expenses incurred before termination unless specifically stated in this Contract.

VALUE-ADDED PROGRAM

Sanford Health Plan may, from time to time, offer health or fitness related programs to our Members through which Members may access discounted rates from certain vendors for products and services available to the general public. Products and services available under any such program are not Covered Services. Any such programs are not guaranteed and could be discontinued at any time. Sanford Health Plan does not endorse any

vendor, product or service associated with such a program and the vendors are solely responsible for the products and services you receive.

LIMITATION PERIOD FOR FILING SUIT

Unless specifically provided otherwise in this Certificate of Coverage, as well as any attachments or amendments appended hereto, or pursuant to applicable law, a suit for benefits under this Certificate of Coverage must be brought within three (3) years after the date of a final decision on the claim, in accordance with the claims procedures outlined in this Certificate of Coverage. See Sections 2 and 10 of this Certificate of Coverage for applicable timelines, and details, on appealing an Adverse Determination.

SUMMARY OF THIS PLAN DESCRIPTION

- This Certificate of Coverage serves as your health benefits policy and describes in detail your Employer's health care benefit plan and governs the coverage. The Certificate of Coverage, and any amendments and/or riders, comprise the entire contract between the Employer and Sanford Health Plan.
- A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate of Coverage carefully. If you have any questions about the benefits as presented in the Certificate of Coverage, please contact your Employer or Sanford Health Plan Customer Service.
- This Certificate of Coverage describes in detail the Covered Services provisions and other terms and conditions of the Plan.
- This Certificate of Coverage does not serve as the ERISA plan document or summary plan description. These are available from your employer. In the event of a conflict, the Certificate of Coverage controls.

NOTICE OF NON-DISCRIMINATION

In compliance with state and federal law, Sanford Health Plan shall not discriminate on the basis of age, gender, sex, color, race, national origin, disability, marital status, sexual preference, religious affiliation, public assistance status, a person's status as a victim of domestic violence or whether an advance directive has been executed. Sanford Health Plan shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew a Certificate of Coverage, (b) terminate coverage, (c) limit benefits, or (d) charge a different Service Charge.
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, contact our Civil Rights Coordinator.

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, you can file a grievance with our Civil Rights Coordinator by calling (800) 752-5863 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free) or writing PO Box 91110, Sioux Falls, SD 57109-1110

You can file a grievance in person or by mail or phone. If you need help filing a grievance, our Civil Rights 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

PLAN DOCUMENTS

This Certificate of Coverage is not intended to serve as the ERISA plan document or summary plan description, which will be provided by your employer. In the event of a conflict this Certificate of Coverage controls.

ENTIRETY OF THE AGREEMENT

Please note that this Contract represents the entire agreement between the parties and that all statements made on behalf of the group to be insured shall, in the absence of fraud, be deemed representations and not warranties. No such statement shall be used in defense to a claim under this Contract unless it is contained in the written application.

Sanford Health Plan will issue a master policy to the employer and these Certificates for delivery to Members. Please notify your employer if you would like to inspect the master policy

SECTION 1.
ENROLLMENT

1.1 WHEN TO ENROLL

An individual must reside within the South Dakota Counties of Minnehaha, Lincoln, or Brown to be an Eligible Group Member under this Certificate of Coverage. An Eligible Group Member must reside in one of the three listed counties for the duration of their Plan Year for services to be covered.

To become a Subscriber, an Eligible Group Member must submit an enrollment application within:

- The applicable Initial Enrollment Period. The Initial Enrollment Period starts on the day the Group Member first becomes an Eligible Group Member, and ends *thirty-one (31)* days later; or
- Any Open Enrollment Period. Open Enrollment is a period of time at least once a year when Eligible Group Members may enroll themselves and their Eligible Dependents in the Plan.

A "Late Entrant" is an Eligible Group Member or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage. A Late Entrant can only enroll during the next scheduled Open Enrollment Period. A Member is not a "Late Entrant" if "special enrollment rights" apply, as described later in this section.

1.2 HOW TO ENROLL

Both the Group and Eligible Group Member are involved in the enrollment process.

The Eligible Group Member must:

1. Complete and sign the enrollment application form, requesting coverage for the Group Member and any Eligible Dependents; and
2. Provide all information needed to determine the eligibility of the Group Member and/or Dependents, if requested by the Plan.

The Group must:

- Submit a written request for coverage of the Eligible Group Member;
- Provide all information needed by Sanford Health Plan to determine eligibility; and
- Agree to pay the required Service Charges on behalf of the Eligible Group Member.

1.3 NOTICE OF NON-DISCRIMINATION DUE TO HEALTH STATUS

Sanford Health Plan is prohibited from discriminating against an Eligible Group Member, or Eligible Dependent, and from refusing enrollment or coverage based on a health factor such as a medical condition (whether physical or mental condition), medical history, disability, or genetic information. Sanford Health Plan does not adjust premiums based on genetic information or use genetic information for underwriting purposes.

1.4 WHEN COVERAGE BEGINS

Coverage generally becomes effective on the first day of the month that follows the date that Sanford Health Plan receives the Group's written request to cover Group Members. A Pre-Existing Condition waiting period may not be applied to any Member.

If not all the requirements for coverage are met immediately, the effective date of coverage may be delayed. However, this delay may not exceed *thirty-one (31)* days from the date that all coverage requirements are met. If an extension under any prior coverage exists, the Plan coordinates benefits.

1.5 ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

Members must reside within the South Dakota Counties of Minnehaha, Lincoln, or Brown as a precondition for coverage under this Certificate of Coverage. It is the Member's responsibility to inform their employer and Sanford Health Plan of any move to a residence outside one of these counties so the member can be moved to an eligible plan. Failure to inform the Member's employer and Sanford Health Plan of a move could result in a denial or reduction of benefits.

The following Dependents are eligible for coverage ("Dependent coverage"):

Spouse - A Spouse, subject to the limitations set forth below.

Dependent Child - To be eligible for coverage, a Dependent Child must satisfy both (1) and (2) below or (3) alone:

Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child.
Be one of the following:

1. under twenty-six (26) years old; or
2. Under twenty-nine (29) years old and enrolled in and attending an accredited college, university, or trade or secondary school on a full-time basis (coverage extends through the month they turn thirty (30) years old). For the purpose of the Plan, the school's definition of "full-time student" shall be used to determine if a Dependent is a full-time student; or
3. incapable of self-sustaining employment by reason of a disabling condition, and chiefly dependent upon the Policyholder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the Dependent Child's disability within *thirty-one (31)* days of the Plan's request.

Dependent of Dependent Child - To be eligible for coverage, a Dependent of Dependent Child must be the Subscriber's grandchild or the grandchild of the Subscriber's living, covered Spouse if (1) the parent of the grandchild is a Member and (2) both the parent of the grandchild and the grandchild are primarily dependent on the Subscriber for financial support. The term grandchild means any of the following:

1. natural child of a Dependent Child;
2. child placed with a Dependent Child for adoption;
3. child legally adopted by a Dependent Child;
4. child for whom a Dependent Child has legal guardianship;

5. stepchild of a Dependent Child; or
6. foster child of a Dependent Child.

NOTE: Dependent coverage does not include the Spouse of a Dependent child. Coverage will continue to the end of the month in which the Dependent Child reaches the limiting age. Coverage does not include the Dependent Child's Spouse or the child of a Dependent Child (grandchild) unless that grandchild meets other coverage criteria established under state law. Until the Dependent Child attains the age of 26, the Dependent Child's marital status, financial status, residency, student status or employment status will not be considered in determining eligibility for initial or continued coverage.

1.6 WHEN AND HOW TO ENROLL DEPENDENTS

A Subscriber shall apply for coverage for a Dependent during the same periods of time that the Subscriber may apply for his or her own coverage. However, there is an exception for newborn and adopted children; see "Coverage from Birth" and "*Children Placed for Adoption*" section below. There is also an exception for Spouses; see "*New Spouses*" section below.

How to Enroll Dependents

The Group Member must Complete and sign an enrollment application form requesting coverage for the Dependent(s); and Agree to pay the required Service Charge, if any.

1.7 WHEN DEPENDENT COVERAGE BEGINS

A. **General**

If a Dependent is enrolled at the same time the Subscriber enrolls for coverage, the Dependent's effective date of coverage will be the same as the Subscriber's effective date.

B. **Delayed Effective Date of Dependent Coverage**

Except for newborns (see "*Coverage from Birth*" section below), if, on the date Dependent coverage becomes effective, the Dependent is Hospitalized and covered under an extension of health benefits under any prior coverage exists, the Plan coordinates benefits. For more details on Coordination of Benefits, see Section 6.

C. **Coverage from Birth**

If a Subscriber has a child through birth, the child will become a covered Dependent from the date of birth, provided that coverage is applied for the child and the required Service Charge payments are made within *thirty-one (31)* days from the child's date of birth. An Eligible Group Member who failed to enroll during a previous enrollment period shall be covered under this Contract from the date of the child's birth, provided that coverage is applied for within *thirty-one (31)* days of the birth and the required Service Charge payments are paid. Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for Group coverage under the Plan, provided that coverage is applied for the Spouse and, if applicable, the Group Member, within *thirty-one (31)* days of the child's birth and the required Service Charge payments are paid.

D. **Adoption or Children Placed for Adoption**

If a Subscriber adopts a child or has a child placed with him or her as a Dependent, that child will become covered as a Dependent from the date of adoption or the beginning of the *six (6)* month adoption bonding period, as noted in the legal adoption papers, provided that coverage is applied for the child within *thirty-one (31)* days from either the date of adoption or the beginning of the *six (6)* month adoption bonding period and

the required Service Charge payments are paid. An Eligible Group Member who failed to enroll during a previous enrollment period shall be covered from the date of the child's adoption or the beginning of the *six (6)* month adoption bonding period, as noted in the legal adoption papers, provided that coverage is applied for within *thirty-one (31)* days of the date of adoption or the beginning of the *six (6)* month adoption bonding period and the required Service Charge payments are paid. Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for Group coverage under the Plan, provided that coverage is applied for the Spouse and, if applicable, the Group Member, provided that coverage is applied for within *thirty-one (31)* days of either the date of adoption or the beginning of the *six (6)* month adoption bonding period and the required Service Charge payments are paid.

E. **New Spouses and Dependent Children**

If a Subscriber gets married, his or her Spouse and any of the Spouse's Dependent Children who become an Eligible Dependent of the Subscriber as a result of the marriage will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for the Spouse and/or the Dependent Children within *thirty-one (31)* days of the date of marriage and the required Service Charge payments are paid. If an Eligible Group Member eligible to be enrolled in the Plan, but who failed to enroll during a previous enrollment period, gets married, the Eligible Group Member, and his or her Spouse, any of the Spouse's Dependent Children who become Eligible Dependents of the Eligible Group Member as a result of the marriage, and any other Eligible Dependents, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for within *thirty-one (31)* days of the date of marriage, and the required Service Charge payments are paid.

1.8 NONCUSTODIAL SUBSCRIBERS

Whenever a Dependent Child receives coverage through the noncustodial parent who is the Subscriber, Sanford Health Plan shall do all of the following:

1. Provide necessary information to the custodial parent in order for the Dependent Child to receive benefits under this Contract;
2. Allow the custodial parent or Provider, with the custodial parent's approval, to submit claims for Covered Services without approval from the noncustodial parent; and
3. Make payment on the submitted claims directly to the custodial parent or Provider.

1.9 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) PROVISION

A QMCSO is an order that creates the right of a Subscriber's Dependent Child to be enrolled in coverage under this Contract. If a QMCSO is issued, Sanford Health Plan will provide benefits to the Dependent Child(ren) of a Subscriber regardless of whether the Dependent Child(ren) reside with the Subscriber. In the event that a QMCSO is issued, each named Dependent Child(ren) will be covered by this Certificate of Coverage in the same manner as any other Dependent Child(ren).

When Sanford Health Plan is in receipt of a medical child support order, Sanford Health Plan will notify the Subscriber and each Dependent Child named in the order, whether or not it is a QMCSO. A QMCSO must contain the following information:

1. Name and last known address of the Subscriber and the Dependent Child(ren) to be covered by the Plan.
2. A description of the type of coverage to be provided to each Dependent Child.
3. The applicable period determined by the order.
4. The plan determined by the order.

In order for the Dependent Child's coverage to become effective as of the date of the court order issued, the Subscriber must apply for coverage as defined previously in this section. Each named Dependent Child may designate another person, such as a custodial guardian, to receive copies of explanation of benefits, checks, and other materials.

Exceptions
If a court has ordered a Subscriber to provide health coverage for a Dependent Child, the above requirements under *Dependent Child* need not be satisfied, but the Subscriber must still request enrollment on behalf of the Dependent Child as set forth in this Certificate of Coverage. If the Subscriber fails to enroll the Dependent Child, the other parent may enroll the Dependent Child. A Dependent Child who is provided coverage pursuant to this exception shall not be terminated unless Sanford Health Plan is provided satisfactory written evidence of any of the following:

1. The court or administrative order is no longer in effect;
2. The Dependent Child(ren) currently receive(s) or will be enrolled in comparable health coverage through a health insurance issuer which will take effect not later than the effective date of the termination; or
3. The Group has eliminated family coverage for all of its Eligible Group Members.

1.10 SPECIAL ENROLLMENT RIGHTS

A Special Enrollment Period may apply when an individual becomes an Eligible Dependent through marriage, birth, adoption, or placement for adoption or when an Eligible Group Member or an Eligible Dependent involuntarily loses other health coverage. To enroll an Eligible Dependent under a Special Enrollment Period, the Eligible Group Member must enroll (or already be enrolled) in coverage under this Contract.

Any Eligible Group Member or Eligible Dependent who was not previously enrolled in coverage under the Contract and has involuntarily lost other health coverage shall be able to enroll in coverage under this Contract within *thirty-one* (31) days after the date of exhaustion of the other health coverage provided that any of the following conditions are met.

1. **Waived Coverage.** The Eligible Group Member or Eligible Dependent:
   (a) was covered under a group health plan or had health insurance coverage at the time coverage under this Contract was initially (upon date of hire) offered to the Eligible Group Member or Eligible Dependent; or
   (b) after subsequently enrolling in other health coverage, had an opportunity to enroll in coverage under this Contract during the Open Enrollment Period or at the time of a Special Enrollment Period, but chose not to enroll; and
   (c) the Eligible Group Member stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment under this Contract, if the Group required such a statement at such time and provided the individual with notice of such requirement at such time.*
2. **Exhausted COBRA.** The Eligible Group Member's or Eligible Dependent's other health coverage was under a COBRA or state continuation provision and such coverage was exhausted.**
3. **Change in Employer Eligibility Rules or Employer Contributions.** The Eligible Group Member's or Eligible Dependent's other health coverage was not under COBRA and either such coverage was terminated as a result of loss of eligibility for such coverage, coverage for a class of similarly situated individuals was terminated, or employer contributions toward such coverage were terminated;

4. **A Move out of the Service Area.** The Eligible Group Member's or Eligible Dependent's other health coverage was terminated because the Eligible Group Member or Eligible Dependent no longer resides, lives or works in the service area for such coverage.
5. **Loss of Eligibility.** The Eligible Group Member's or Eligible Dependent's coverage under the other health coverage terminated due to a loss of eligibility under the terms of such coverage.

* *Loss of coverage due to failure to make premium payment and/or allowable rescissions of coverage does not qualify for a Special Enrollment Period.*

* *Voluntarily terminating/dropping COBRA coverage before it runs out does not qualify for a Special Enrollment Period.*

Requests for Special Enrollment must be received by Sanford Health Plan no later than *thirty-one (31)* days after the date of exhaustion or termination of coverage.

1.11 CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

The Children's Health Insurance Program (CHIP) Reauthorization Act of 2009 grants special enrollment rights to employees and Dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

- Losing eligibility for coverage under a State Medicaid or CHIP program, or
- Becoming eligible for State premium assistance under Medicaid or CHIP.

In order to qualify for special enrollment, an eligible employee or dependent must request coverage within *sixty (60) days* of either being terminated from Medicaid or CHIP coverage, or being determined to be eligible for federal premium assistance. In either situation, the Plan will also require the eligible employee to enroll in Plan coverage. Special enrollment rights extend to all benefit packages available under the Plan. If you have questions about enrolling in your employer plan under CHIPRA special enrollment rights, contact the U.S. Department of Labor at www.askebsa.dol.gov or call (866) 444-3272 *(toll-free)*.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **(877) KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply.

SECTION 2
HOW YOU GET CARE

2.1 IDENTIFICATION CARDS

Sanford Health Plan will send you an identification (ID) card when you enroll. Each Subscriber will receive their own Member ID card after enrollment, which should be used when you receive care. If you fail to show your ID card at the time you receive Health Care Services, you will be responsible for payment of the claim after the In-Network Participating Practitioner and/or Provider's timely filing period of *one-hundred-eighty* (180) calendar days has expired. Your coverage will be terminated if you use your ID card fraudulently or allow another individual to use your ID card to obtain services.

If you do not receive your ID card within *thirty* (30) calendar days after the effective date of your enrollment, you need a temporary card or replacement cards, please contact us or log in to the member portal within Epic MyChart, at sanfordhealthplan.com/memberlogin.

2.2 CONDITIONS FOR COVERAGE

Members are entitled to coverage for the Health Care Services (listed in the "Covered Services," in Section 3 that are:

1. Medically Necessary and/or Preventive; and
2. Received from or provided under the orders or direction of an In-Network Participating Practitioner and/or Provider, or approved by Sanford Health Plan.

However, this specific condition does not apply to Emergency Medical Conditions or urgent care in and out of the Service Area. In such cases, the services will be covered if they are provided by a Non-Participating or Out-of-Network Provider.

If during an emergency or Urgent care situation, the Member is in the Service Area and is alert, oriented and able to communicate (as documented in medical records); the Member must direct the ambulance to the nearest In-Network Participating Practitioner and/or Provider.

Members are not required, but strongly encouraged, to select a Primary Care Physician and use that Physician to coordinate their Health Care Services.

Members must reside within the South Dakota Counties of Minnehaha, Lincoln, or Brown as a precondition for coverage under this Certificate of Coverage. It is the Member's responsibility to inform their employer and Sanford Health Plan of any move to a residence outside one of these counties so the member can be moved to an eligible plan. Failure to inform the Member's employer and Sanford Health Plan of a move could result in a denial or reduction of benefits

In addition, all Health Care Services are subject to:

1. The exclusions and limitations described in Sections 3 and 4; and
2. Any applicable Copay, Deductible, and Coinsurance amount as stated in your Summary of Benefits and Coverage (SBC).

2.3 IN-NETWORK AND OUT-OF-NETWORK COVERAGE

There are *two* (2) levels of coverage that are available:
1. In-Network Coverage; and
2. Out-of-Network Coverage. *For Out-of-Network coverage, please see Section 3.7.*

NOTE: This Certificate of Coverage does not cover most Out-of-Network services. ***For Out-of-Network coverage, please see Section 3.7***

In-Network Coverage means Covered Services that are either received:

1. From an In-Network Participating Practitioner and/or Provider within the Service Area; or
2. From a Participating Provider outside of the Service Area if an In-Network Participating Practitioner and/or Provider has recommended the referral, and
   a. Sanford Health Plan has authorized the referral to a Participating Provider outside of the Service Area or
   b. Sanford Health Plan has authorized the referral from an In-Network Participating Practitioner and/or Provider to a Non-Participating Provider or Out-of-Network Participating Provider; or
3. When experiencing an Emergency Medical Condition or in an Urgent Care Situation; or
4. When the Member does not have appropriate access to In-Network Participating Practitioner and/or Provider.

For *Appropriate Access* standards, see below.

NOTE: There is no coverage for Medically Necessary Health Care Services, other than during an Emergency Medical Condition or Urgent Care Situation, if you travel out of the Service Area for the purpose of seeking medical treatment outside the Service Area, unless care is received from an In-Network Participating Practitioner and/or Provider. Additionally, if you choose to go to a Non-Participating or an Out-of-Network Provider when access to an In-Network Participating Practitioner and/or Provider is available, your claims will be paid according to your Out-of-Network Coverage.

In the following circumstances, Medically Necessary Health Care Services received from Non-Participating Providers may be Covered Services subject to In Network Cost Sharing, although Members may be responsible for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services.

1. **Ancillary Health Care Services**. Health Care Services received from a Non-Participating Provider that are ancillary to a Covered Service being provided by In-Network Participating Practitioner and/or Provider, such as anesthesiology or radiology, if rendered in an In-Network Facility. Any payment by the Member for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services will count towards the Out-of-Pocket Maximum Amount applicable to In Network Benefits.
2. **Termination of a Participating Provider.** Health Care Services received from a Participating Provider by a Member who is under an Active Course of Treatment and we terminate the Participating Provider's status as a Participating Provider without cause. The Member or the terminated Participating Provider must request and receive written approval from us. Any payment by the Member for the difference between the amount charged by the Non-Participating Provider and Sanford Health Plan's payment for Covered Services will not count towards the Out-of-Pocket Maximum Amount applicable to In Network Benefits.

2.4 APPROPRIATE ACCESS

Primary Care Physicians and Hospital Providers

Appropriate access for In-Network Participating Practitioner and/or Providers who provide primary care services and Hospital Provider sites is within *thirty* (30) miles of a Member's city of legal residence

Specialty Practitioners and Providers

For other types of In-Network Participating Practitioner and/or Providers such as Specialty Physicians, Diagnostic Service Centers, Nursing Homes, and Rehabilitation Providers, appropriate access is within ninety (90) miles of a Member's city of legal residence. If you are traveling within the Service Area where other In-Network Participating Practitioner and/or Providers are available, then you must use In-Network Participating Practitioner and/or Providers.

Members who live outside of the Service Area must use Participating Practitioners and Providers as indicated on the Member Welcome Letter attached to the Member Identification Card. Members who live outside the Service Area will receive ID Cards that display their network logo along with instructions on how to access Participating Providers. If a Member chooses to go to a Non-Participating or Out-of-Network Provider when appropriate access (within *ninety* (90) miles of a Member's city of legal residence) is available, claims will be processed at the Out-of-Network Coverage Level.

Transplant Services

Transplant Services must be performed at designated participating facilities and are not subject to the appropriate access standards outlined above. Transplant coverage includes related post-surgical treatment, drugs, eligible travel, and living expenses and shall be subject to and in accordance with the provisions, limitations and terms of Sanford Health Plan's transplant policy.

Second Opinions

If you question a decision about medical care, we cover a second opinion from a health care professional qualified in diagnosis and treatment of your condition(s). We encourages you to use a Sanford Health Plan In-Network Participating Practitioner and/or Provider**.**

Referrals

There is no referral requirement for services delivered by Sanford Health Plan In-Network Participating Practitioner and/or Provider.

2.5 CASE MANAGEMENT

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes.

Cases are identified for possible case management, based on a request for review or the presence of a number of parameters, such as:

1. admissions that exceed the recommended or approved length of stay;
2. utilization of health care services that generates ongoing and/or excessively high costs;
3. conditions that are known to require extensive and/or long term follow up care and/or treatment.

Sanford Health Plan's case management process allows professional case managers to assist Members with certain complex and/or chronic health issues by coordinating treatment and/or other types patient care plans.

NOTE: For certain transplant procedures, case management services will be provided by the Plan's transplant vendor, *not* Sanford Health Plan. For benefit details on transplant services, see Section 3.2.

2.6 BENEFIT DETERMINATION REVIEW PROCESS

Sanford Health Plan Appeals and Complaints Department reviews all non-medical benefit determinations through review of Certificate of Coverage language, contractual terms, administrative policies related to benefits as defined by this Policy, and benefits requests. All benefit determinations that are Adverse will be made by the person assigned to coordinate Benefit, Denial, and Appeal processes.

The Appeals and Complaints Department is available between the hours of 8 a.m. and 5 p.m. Central Time, Monday through Friday, by calling Sanford Health Plan's toll-free number (877) 652-8544 | TTY/TDD: (877) 652-1844 *(toll-free)*. After these business hours, you may leave a confidential voicemail and someone will return your call on the next business day. You may also fax Sanford Health Plan at (605) 312-8910.

The date of receipt for non-urgent (standard) requests received outside of normal business hours will be the next business day.

2.7 ROUTINE (NON-URGENT) PRE-SERVICE BENEFIT REQUESTS

All pre-service benefit determination (approval) requests will be determined within fifteen (15) business days of receipt of the request. When a preauthorization (pre-approval) request is received before a service occurs, the date of receipt for non-urgent (standard) requests is the date the Plan receives the Member's request. If the request is made outside of business hours, the date or receipt will be next business day. If Sanford Health Plan denies a benefit (an Adverse Benefit Determination) the Plan will contact the Member via mail.

2.8 ROUTINE POST-SERVICE BENEFIT REQUESTS

Retrospective (post-service) requests occur when a Member has already utilized healthcare services and did not inquire about coverage pre-service. Post-service requests are not related documentation, coding or reimbursement from the Plan. Sanford Health Plan will review and approve or deny the service based on Medical Necessity within thirty (30) calendar days of receipt of the request. A letter will be sent to the Member within those 30 calendar days with the Plan's determination

2.9 UTILIZATION MANAGEMENT REVIEW PROCESS

Utilization Management is available between the hours of 8:00 am and 5:00 pm Central Time, Monday through Friday, by calling us at toll-free number (800) 805-7938 | TTY/TDD: (877) 652-1844 *(toll-free)*. After these business hours, you may leave a confidential voicemail for Utilization Management and someone will return your call on the next business day. You may also fax us at (605) 328-6813.

The date of receipt for non-urgent requests received outside of normal business hours will be the next business day. The date of receipt for urgent requests will be the actual date of receipt, whether or not it is during normal business hours.

All Utilization Review Adverse Determinations will be made by the Sanford Health Plan Chief Medical Officer or appropriate Practitioner.

Claims for benefits under the Plan can be post-service, pre-service, or concurrent. This part of Section 2 explains how we process different types of claims.

Designating an Authorized Representative

You may act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. An Authorized Representative is someone you designate in writing to act on your behalf. We have developed a form that you must complete if you wish to designate an Authorized Representative. You can get the form by calling Customer Service toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844 *(toll-free)*. You can also log into your account at www.sanfordhealthplan.com/memberlogin and download a copy of the form. If a person is not properly designated as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Policy.

For urgent pre-service claims, we will presume that your Provider is your Authorized Representative unless you tell us otherwise in writing.

Your Right to Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as Medical Necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that advice), you may request that we give you the name of that person. Reasons for any denial or reimbursement or payment for services with respect to benefits under the Plan will be provided within 30 business days of a request. We will not charge you for any information that you request regarding our decision.

Your Complaint (Grievance) & Appeal Rights

If you are dissatisfied with our handling of a claim or have any questions or complaints, you may do one or more of the following:

- You may call or write the Appeals and Complaints Department. We will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received; or

- You may file an Appeal if you have received an Adverse Benefit Determination. Please see Section 10 for more information on the Appeals Process.

The Plan's claims procedures are designed to comply with the requirements of ERISA. Because this Plan is subject to ERISA, we will process your claim according to ERISA standards and provide you with ERISA appeal rights. In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), criteria for Medical Necessity determinations is available upon request to any current or potential Member, beneficiary, or contracting provider. For details on the complaint and appeals process, see Section 10.

NOTE: If you receive an Adverse Determination, you have the right to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not (and is not) considered a request for an Internal Appeal and/or External Review.

2.10 PROSPECTIVE (PRE-SERVICE) REVIEW OF SERVICES (CERTIFICATION PRIOR AUTHORIZATION)

Prior Authorization (also referred to as Certification) is a decision by the Plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary and appropriate. Preauthorization is required for services as defined above, except in urgent or emergent situations. Although the Plan may authorize a health care service as medically necessary, it is not a guarantee the Plan will cover the cost.

Determination of the appropriateness of care is based on standard review criteria and assessment of the following factors:

- The Member's medical information, including diagnosis, medical history and the presence of complications and/or comorbidities.
- Consultation with the treating Practitioner and/or Provider, as appropriate.
- Availability of resources and alternate modes of treatment. For admissions to Facilities, other than Hospitals, additional information may include but is not limited to history of present illness, patient treatment plan and goals, prognosis, staff qualifications and *twenty-four* (24) hour availability of qualified medical staff.
- Sanford Health Plan does not compensate Practitioners, Providers or other individuals conducting Utilization Review for issuing denials of coverage or service care. Any financial incentives offered to Utilization Review decision makers do not encourage decisions that result in underutilization and do not encourage denials of coverage or service.

Prior Authorization is the responsibility of your Practitioner and/or Provider. For an up to date list or more information on all things that require prior authorization, please visit:

- https://www.sanfordhealthplan.org/members/prior-authorization.

2.12 PHARMACY PRE-APPROVAL (CERTIFICATION) REQUESTS

Certain specialty drugs, or those which require frequent dosing adjustments, close monitoring, special training, compliance assistance, or need special handling and/or administration, require preauthorization by the Pharmacy Management Department.

To acquire preauthorization for a medication, ask the prescribing Practitioner and/or Provider to contact us by phone, complete the Formulary Exception Form found online at sanfordhealthplan.com, or provide a letter of Medically Necessity. This applies to any request of:

1) A non-covered medication or drug; or
2) A medication, or drug not currently listed in the Formulary.

Sanford Health Plan will use appropriate practitioners to consider requests and grant an exceptions to the Formulary when the prescribing Practitioner and/or Provider of the drug attests the Formulary drug causes an adverse reaction, is considered contraindicated, or must be dispensed as written to provide maximum medical benefit to the Member.

The Pharmacy Management department will review the request and make a decision based on:

1. Medical records showing trial and failure of a formulary drug or reasons why a formulary drug trial should be avoided;
2. Clinical information (such as diagnosis, disease progression and/or medication history); and
3. Medical Necessity.

Drugs and associated expenses and devices not approved by the FDA for a particular use are not covered except as a required by law (unless Provider certifies off-label use with a letter of medical necessity)

If the reason for the exception is not clear, the reviewing clinician will contact the prescribing Practitioner and/or Provider to discuss the request. Additionally, if necessary, a clinical consultant of the appropriate specialty may be consulted for review.

If a Formulary exception is granted, the Pharmacy Management Department will provide authorization to the Plan's Pharmacy Benefit Manager so the Member is able to obtain the requested medication immediately. Additionally, coverage of the non-Formulary drug will be provided for the duration of the prescription, including refills.

For more information on drugs that may require prior authorization including oral medications, step therapy and injectable medications, refer to the formulary and Section 3.5 of this document.

Routine/Standard Pharmacy Pre-Approval Requests

Routine/Standard (non-urgent) pharmacy pre-approval requests will be reviewed within **fifteen (15) days after receipt of the request.** If the request is made outside of business hours, the date or receipt will be next business day.

Urgent Pharmacy Pre-Approval Requests

Urgent pharmacy pre-approval requests be reviewed as soon as possible and no later than **twenty-four (24) hours** of receipt of the request. Sanford Health Plan in alignment with the Standard and Expedited Exception Request requirements. Requests will be considered urgent if the Member's health is in serious jeopardy, or the Member's Practitioner and/or Provider states the Member may experience severe pain that cannot be controlled while waiting for the Plan's decision.

How to Request Pre-Approval for a Drug

You or your authorized representative can request a medication pre-approval by:

- Contacting Pharmacy Management at (605) 312-2756
- Complete Formulary Exception Form found online at sanfordhealthplan.com
- Ask the prescribing Practitioner and/or Provider for a letter of medical necessity

  Mail to: Sanford Health Plan, PO Box 91110,
  Attention: Pharmacy Management,
  Sioux Falls, SD 57110
  Fax to: (605) 328-6813
- Ask the prescribing Practitioner and/or Provider to contact the Plan by phone

What to Include with the Request

Send all information supporting your request to the Plan for review. This may include written comments, doctor's notes, documents, or any other information you think would help us approve your request. Your practitioner and/or provider may be able to help you obtain this information.

Notification of the Decision (Determination)

The Plan will notify the Member, their Authorized Representative, and/or Practitioner and/or Provider submitting the request of the Plan's decision.

2.13 ADDITIONAL INFORMATION REGARDING FORMULARY EXCEPTION REQUESTS

1. For contraceptives not in the Formulary, if the prescribing Practitioner and/or Provider determines that a drug/device is Medically Necessary and an exception to the formulary is granted, the contraceptive drug/device will be covered at 100% (no charge).
2. If the decision is to approve a standard (routine) Formulary exception request, the Plan will provide coverage of the non-Formulary drug for the duration of the prescription, including refills. If a request is granted based on an emergent circumstance, Sanford Health Plan will provide coverage of for the duration of the incident.
3. In the event that an exception request is granted, Sanford Health Plan will treat the excepted drug(s) as an essential health benefit, including, if applicable per the Member's Policy, counting any cost-sharing towards the Member's annual limitation on cost-sharing and when calculating the actuarial value.

In determining whether to grant an exception, Sanford Health Plan adheres to, procedures, as outlined above, allowing Members to request and gain access to clinically appropriate drugs not covered under the Plan's Formulary.

2.14 MEDICAL PRE-APPROVAL (CERTIFICATION) REQUESTS

All requests for Prior Authorization (Certification) are to be made by the Physician/Practitioner's office at least *three (3)* business days prior to the scheduled admission or requested service. The Utilization Management Department will review the Member's medical request against standard criteria.

Determination of the appropriateness of an admission is based on standard review criteria and assessment of:

1. Member medical information including:
   a. diagnosis;
   b. medical history;

    c. presence of complications and/or co-morbidities;
2. Consultation with the treating Practitioner, as appropriate;
3. Availability of resources and alternate modes of treatment; and
4. For admissions to Facilities other than acute general Hospitals, additional information may include but is not limited to the following:
    a. history of present illness;
    b. patient treatment plan and goals;
    c. prognosis;
    d. staff qualifications; and
    e. twenty-*four (24)* hour availability of qualified medical staff.

Routine Pre-Service Pre-Approval Requests

Routine/Standard (non-urgent) pre-service requests for services that require pre-approval from the Plan will be made within **fifteen (15) calendar days from the date** the Plan receives the request. If the request is made outside of business hours, the date or receipt will be next business day. If a request does not follow the Pre-Approval (Authorization/Certification) Procedure as outlined in this document, we will notify the Member or Practitioner and/or Provider no later than **five (5) calendar days** after the date of the failure. Notification may be oral unless the Member or Practitioner and/or Provider request written notification.

Urgent Pre-Service Pre-Approval Requests

Urgent pre-service requests for services that require pre-approval from the Plan will be reviewed as soon as possible and no later than twenty-four **(24) hours** after receipt of the request. Requests will be considered urgent if the Member's health is in serious jeopardy, or the Member's Practitioner and/or Provider states the Member may experience severe pain that cannot be controlled while waiting for the Plan's decision. If the request does not meet the definition of urgent, or is for a service that has already occurred, (post-service/retrospective) the request will be processed as a routine/standard request.

If a request does not follow the Pre-Approval (Authorization/Certification) Procedure as outlined in this document, we will notify the Member or Practitioner and/or Provider no later than **twenty-four (24) hours** after the date of the failure. Notification may be oral unless the Member or Practitioner and/or Provider request written notification.

Emergent Medical Conditions

Pre-approval is not required if a prudent layperson that possesses an average knowledge of health and medicine determines urgent or emergent care is necessary in a particular situation. Members should notify Sanford Health Plan as soon as reasonably possible and no later than **forty-eight (48) hours** after physically or mentally able to do so. A Member's Authorized Representative may also notify the Plan on the Member's behalf.

How to Request Pre-Approval for a Medical Item or Health Care Service
You or your authorized representative can request a medical pre-approval request by:

- Contacting Utilization Management at (605) 328-6807
- Mail the Medical Authorization Request Form to: Sanford Health Plan, PO Box 91110, Attention: Utilization Management, Sioux Falls, SD 57109

- Fax to: (605) 328-6813

What to Include with a Pre-Approval Request

Send all information supporting your request to the Plan for review. This may include written comments, doctor's notes, documents, or any other information you think would help us approve your request. Your practitioner and/or provider may be able to help you obtain this information.

Lack of Necessary Information

If the Plan is unable to make a decision due to lack of necessary medical information, we will notify the Member, their Authorized Representative (if applicable) and their Practitioner and/or Provider regarding what information is necessary to approve the request. If request was received from a Practitioner and/or Provider, the Plan will communicate solely with the requesting Practitioner and/or Provider regarding information needed to approve the request. The Plan will notify the appropriate party(ies) regarding the information needed to make a decision within:

- **Twenty-four (24) hours** of the receipt of the request if the request meets the definition of Urgent. The Plan will provide **forty-eight (48) hours** to supply the requested information. If not received by the end of the 48-hour extension, the request will be denied.
- **Fifteen (15) calendar days** of receipt of a routine/standard request. The Plan will provide forty-five (45) calendar days to supply the requested information. If not received by the end of the forty-five day extension, the request will be denied.

Notification of the Decision (Determination)

The Plan will notify the Member, their Authorized Representative, and/or Practitioner and/or Provider submitting the request of the Plan's decision:

- By phone no later than **forty-eight (48) hours** after the decision is made for Urgent requests. The Plan will also provide electronic or written notification of the decision as soon as possible, but no later than within **three (3) calendar days** of the phone notification if the request is deemed urgent.
- By mail within the **fifteen (15) calendar days** after receipt of the request.

Routine/Standard (Non-Urgent) Post-Service Pre-Approval Request

If a claim is denied for a service that has already occurred or item that has already been received (post-service or retrospective), the Member may file an appeal as outlined in Section 10 as the denied claim serves as the initial adverse determination.

2.15 ONGOING (CONCURRENT) PREAUTHORIZATION REQUESTS (CERTIFICATION) OF HEALTH CARE SERVICES

Concurrent Review is utilized when a request for an extension of an approved ongoing course of treatment for medical care, including care for behavioral, mental health, and/or substance use disorders, over a period of time

or number of treatments, is warranted. Additional stay days must meet the continued stay review criteria and, if acute levels of care criteria are not met, a decision to certify further treatment must be made at that time.

Determinations by us to Limit or Reduce Previously Approved Care

If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give you advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow the rules we establish for the filing of your appeal, such as the time limits within which the appeal must be filed (See Section 10 for more information on the Appeals Process). Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow you to appeal and obtain a review determination before the benefit is reduced or terminated. In addition, individuals in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process.

Prior Authorization of inpatient care stays will terminate on the date the Member is to be discharged from the Hospital or other Facility (as ordered by the attending Physician). Hospital/Facility days accumulated beyond ordered discharge date will not be certified unless the continued stay criteria continue to be met. Charges by Practitioner and/or Providers associated with these non-certified days are Non-Covered.

Authorization (Certification) of Inpatient health care stays will terminate on the date the Member is to be discharged from the Hospital or Facility (as ordered by the attending Physician). Hospital/Facility days accumulated beyond ordered discharge date will not be certified unless the continued stay criteria continue to be met. Charges by Practitioner and/or Providers associated with these non-certified days will be considered non-covered.

The health care service or treatment that is the subject of the Adverse Determination shall be continued without liability to the Member until the Member or the Member's Authorized Representative has been notified of the determination with respect to the internal review request made pursuant to the Appeal Procedures.

Any reduction or termination during the course of treatment before the end of the period or number treatments shall constitute an Adverse Determination.

Requests to Extend Previously Approved Care

A Provider who is requesting an extension of an approved ongoing course of treatment beyond the ordered period of time or number of treatments must request Prior Authorization from Sanford Health Plan at least *twenty-four (24) hours* in advance of the termination of such continuing services. Your Provider may make this request in writing or orally directly to us. To request a concurrent review determination, call Utilization Management at (800) 805-7938 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*.

If Utilization Management denies the extension of treatment, it will advise the Member and Practitioners and/or Providers within twenty-four (24) hours of receiving the request. If the Member decides to appeal this denial, the health care services or treatment subject to the Adverse Determination shall be continued without cost to the Member while the determination is under review as specified by the Appeal procedures outlined in Section 10.

If the internal review process results in a denial of the request for an extension, the payment of benefits for such treatment shall terminate but the Member may pursue the appeal rights described in Section 10.

Any reduction or termination by the Plan during the course of treatment before the end of the period or number of treatments shall constitute an Adverse Determination.

For requests to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, Sanford Health Plan shall make a determination and orally notify the Member, or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service, of the determination as soon as possible, taking into account the Member's medical condition, but in no event more than twenty-four (24) hours after the date of Sanford Health Plan's receipt of the request.

Sanford Health Plan will provide electronic or written notification of an authorization to the Member, Practitioner and those Providers involved in the provision of the service within three (3) calendar days after the oral notification.

We shall provide written or electronic notification of the Adverse Determination to the Member and those Providers involved in the provision of the service sufficiently in advance (but no later than within three (3) calendar days of the telephone notification) of the reduction or termination to allow the Member or, the Member's Authorized Representative to file a Grievance request to review of the Adverse Determination and obtain a determination with respect to that review before the benefit is reduced or terminated. Sanford Health Plan will terminate payment of benefits on the date that oral notification of the reduction or termination of benefits is made. In cases where the Member is not at financial risk, Members will not be notified of an Adverse Determination unless the decision has the potential to adversely affect the Member, in terms of coverage or financially, whether immediate or in the future.

Non-Urgent (Standard) Concurrent Reviews

If your request is non-urgent, we will treat it as a new claim for benefits, and will make a determination on your claim within the pre-service or post-service timeframes as outlined in this Section.

Urgent (Expedited) Concurrent Reviews

If your request for additional care is urgent, and if your Provider submits it no later than twenty-four (24) hours before the end of your pre-approved stay or course of treatment, Sanford Health Plan will make the decision as soon as possible (taking into account the medical exigencies) but no later than twenty-four (24) hours after receiving the request]. For authorizations and denials, we will give telephone notification of the decision to Members, Practitioners and those Providers involved in the provision of the service within twenty-four (24) hours of receipt of the request. We will give oral, written or electronic notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service as soon as possible but no later than within three (3) calendar days of the oral notification.

If your Provider attempt to file an urgent concurrent review but fails to follow our procedures for doing so, we will notify you and your Provider of the failure within twenty-four (24) hours. Our notification may be oral, unless asked for in writing.

Adverse Determinations

If the determination is an Adverse Determination, we shall provide written notice in accordance with the Written Notification Process for Adverse Determinations procedures outlined below. At this point, the Member can request an appeal of Adverse Determinations. Refer to the "Appeal Procedures" in Section 10 for details.

Lack of Necessary Information

If we need more information, we will let you know within twenty (24) hours of your claim. Sanford Health Plan will tell you what further information is needed. You will then have forty-eight (48) hours to provide us with the additional information. Sanford Health Plan will notify you of our decision within forty-eight (48) hours after we receive all requested information.

Our notification may be oral; if it is, we will follow it up in writing within three (3) days. If we do not receive the information, your claim will be considered denied at the expiration of the forty-eight (48) hours we gave you for furnishing the information to us.

2.16 WRITTEN NOTIFICATION PROCESS FOR ADVERSE DETERMINATIONS

The written notifications for Adverse Determinations will include the following:

1. The specific reason for the Adverse Determination in easily understandable language;

2. Reference to the specific provision, guideline, or protocol on which the determination was based and notification that the Member will be provided a copy of the actual provisions, guidelines, and protocols free of charge upon request. Reasons for any denial or reimbursement or payment for services with respect to benefits under the plan will be provided within 30 business days of a request;

3. Notice of an Adverse Determination will include information sufficient to identify the claim involved, including the date of service the Provider, the claim amount (if applicable) and a statement notifying members of their opportunity to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not be (and is not) considered a request for an internal appeal or external review;

4. If the Adverse Determination is based in whole or in part upon the Member failing to submit necessary information, the notice shall include a description of any additional material or information, which the Member failed to provide to support the request, including an explanation of why the material is necessary;

5. If the Adverse Determination is based on Medical Necessity or an Experimental or Investigational Service or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the coverage to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;

6. For Mental Health and/or Substance Use Disorder (MH/SUD) Adverse Determinations, if information on any Medical Necessity criteria is requested, documents will be provided for both MH/SUD and medical/surgical benefits within 30 business days of a Member/Authorized Representative/Provider's request. This information will include documentation of processes, strategies, evidentiary standards and other factors used by the plan, in compliance with MHPAEA;

7. If the Adverse Determination is based on Medical Necessity, a written statement of clinical rationale,

including clinical review criteria used to make the decision if applicable. If the denial is due to a lack of clinical information, a reference to the clinical criteria that have not been met will be included in the letter. If there is insufficient clinical information to reference a specific clinical practice guideline or policy, the letter will state the inability to reference the specific criteria and will describe the information needed to render a decision;

8. A description of appeal procedures, including how to obtain an expedited review if necessary (and any time limits applicable to those procedures) including:

    a. a Member's right to bring civil action under §502(a) of ERISA;
    b. the right to submit written comments, documents or other information relevant to the appeal;
    c. an explanation of the Appeal process including the right to Member representation;
    d. notification that Expedited External Review can occur concurrently with the internal Appeal process for urgent care/ongoing treatment; and
    e. the timeframe the Member has to make an appeal and the amount of time the Plan has to decide it (including the different timeframes for Expedited Appeals);

9. If the Adverse Determination is based on Medical Necessity, notification and instructions on how the Practitioner can contact the Practitioner to discuss the determination;

10. You have the right to contact the South Dakota Division of Insurance at any time at:

South Dakota Department of Revenue & Regulation
Division of Insurance
445 East Capitol Avenue
Pierre, SD 57501-3185
Phone: (605) 773-3563
Fax: (605 773-5369

SECTION 3
COVERED SERVICES – OVERVIEW

Subject to the terms and conditions set forth in this Contract, including any exclusions or limitations, this Contract provides coverage for the following Covered Services. Payment for Covered Services is limited by or subject to any applicable Coinsurance, Copay, or Deductible set forth in this Contract including the Summary of Benefits and Coverage. To receive maximum coverage for Covered Services, the terms of this Contract must be followed, including receipt of care from In-Network Participating Practitioner and/or Providers as well as obtaining any required Certification. You are responsible for all expenses incurred for Non-Covered Services. Health Care Services received from Non-Participating Providers or Out-of-Network Participating Providers are Non-Covered Services unless otherwise indicated in this Contract.

3.1 HEALTH CARE SERVICES PROVIDED BY PRACTITIONERS AND PROVIDERS

Here are some important things you should keep in mind about these benefits:

- *Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *You or your Practitioner and/or Provider must get Certification of some services in this Section. The benefit description will say "**NOTE**: Certification is required for certain services. Failure to get Certification will result in a reduction or denial of benefits (See Services requiring Certification in Section 2.).*

3.1.1 ARTIFICIAL NUTRITION

NOTE: This requires Certification; failure to get Certification may result in a reduction or denial of benefits.

- Parenteral nutrition formula and supplies
- Enteral nutrition formula and supplies

3.1.2 ALLERGY CARE BENEFITS

- Testing and treatment
- Allergy injections
- Allergy serum

3.1.3 CARDIAC REHABILITATION

- Cardiac rehabilitation delivered as part of an inpatient hospitalization
- Outpatient cardiac rehabilitation is a covered benefit when referred by a physician and provided under the general supervision of a physician (limited to 36 visits per calendar year)

3.1.4 CHIROPRACTIC SERVICES

- Non-Surgical Spinal treatment and chiropractic services

- Limited to twenty (20) visits each Calendar Year, regardless of whether performed by a chiropractor or other licensed Provider authorized to perform such services

3.1.5 CLINICAL TRIALS

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

- Routine Patient Costs when provided as part of an Approved Clinical Trial if the services are otherwise Covered Services. An In-Network Participating Practitioner and/or Provider must provide Sanford Health Plan notice of a Member's participation in an Approved Clinical Trial.
- Routine Patient Costs means the cost of Medically Necessary Health Care Services related to the care method that is under evaluation in an Approved Clinical Trial. Routine Patient Costs do not include any of the following.
    - The Health Care Service that is the subject of the Approved Clinical Trial.
    - Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service that is the subject of the Approved Clinical Trial.
    - Any Health Care Service provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
    - An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
    - Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where an Approved Clinical Trial is conducted.
    - A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.
    - Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

3.1.6 DIABETES SUPPLIES, EQUIPMENT AND EDUCATION BENEFITS

NOTE: Indicated Durable Medical Equipment (DME) requires Certification; failure to get Certification may result in a reduction or denial of benefits.

Item (* Certification Required)	**Must be obtained at:**	**Benefit/Cost Information**
• Blood Glucose test stripes • Glucagon • Glucometers • Glucose Agents • Lancets and lancet devices • Prescribed oral agents for controlling blood sugars	Pharmacy (prescription required)	Pharmacy Benefit Depending on plan, copay or deductible/coinsurance may apply

• Syringes • Urine testing strips		
• Continuous Glucose Monitor Receiver* • Custom diabetic shoes and inserts limited to *one (1) pair* of depth- inlay shoes and *three (3) pairs* of inserts; or *one (1) pair* of custom molded shoes (including inserts) and *three (3)* additional pairs of inserts • Insulin infusion devices*Insulin Pump*	Durable Medical Provider	Medical Benefit Deductible/Coinsurance will apply

Coverage for the treatment of diabetes includes:

- Routine foot care, including toenailtrimming is covered.
- Diabetes self-management training and education shall only be covered if:
    a. the service is provided by a Physician, nurse, dietitian, pharmacist or other licensed health care Practitioner and/or Provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified by a diabetes educator; and
    b. the training and education is based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association or the South Dakota Department on Health.

3.1.7 DIAGNOSTIC AND TREATMENT SERVICES

Professional services from Practitioners, Providers, Physicians, nurse practitioners, and Physician's assistants are covered when provided in Practitioner and/or Provider's offices and urgent care centers. Medical office consultations and second surgical opinions are also covered per Medical Necessity.

3.1.8 DIALYSIS BENEFIT

Services include equipment, training, and medical supplies required for effective dialysis care.

3.1.9 DURABLE MEDICAL EQUIPMENT (DME) BENEFITS

- Coverage is available for DME equipment prescribed by an attending Practitioner and/or Provider, which is Medically Necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury. Limitations per Sanford Health Plan policy guidelines apply.

- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Sanford Health Plan policy.
- Prior Approval is required for certain items. For updated information refer to:
    - https://www.sanfordhealthplan.org/members/prior-authorization.

3.1.10 EYE CARE SERVICES

- Cataract Surgery.
- Dilated eye examination for diabetes-related diagnosis (limit of one exam per Member per year)
- Eyeglasses or contact lenses for aphakia patients or soft contact lenses or scleral shells intended for the use in the treatment of a disease or injury
    - Eyeglasses, including lenses and one (1) frame per lifetime or clear contact lenses for the aphakia eye will be covered for two (2) single lens per Calendar Year
    - Scleral Shells: Soft shells limited to two (2) per Calendar Year. Hard shells limited to one (1) per lifetime
- Services required because of injury, accident or cancer that damages the eye, as long as the Member was covered under this Contract during the time of the injury or illness causing the damage.
- Vision therapy

3.1.11 FAMILY PLANNING BENEFITS

1. Consultations and pre-pregnancy planning.
2. Member education and counseling, as prescribed by a health care provider for women with reproductive capacity.
3. Voluntary Sterilizations, including tubal ligations and vasectomies. Applicable cost sharing may apply; see contraceptive coverage covered without cost-sharing below.
4. Folic acid supplements are covered at 100% (no cost) for women planning to become pregnant or in their childbearing years.
5. Sanford Health Plan covers, without cost-sharing, at least one form of contraception in each of the eighteen (18) methods below that the FDA has identified for women in its current Birth Control Guide. These methods fall into three (3) categories.
    1. Obtained during an office visit/medical procedure:
        i. Surgical sterilization implant/occlusion of the fallopian tubes by use of permanent implants
        ii. Sterilization surgery/tubal ligation covered at 100% only when performed as the primary procedure
        iii. Implantable devices (Placement and removal is covered per device guidelines or as Medically Necessary). Includes
            1. Implantable rod.
            2. IUD Copper
            3. IUD Progestin
        iv. Shot/Injection: includes injectable medroxyprogesterone acetate
        v. Cervical Cap.
    2. Obtained with a prescription:
        i. Oral Contraceptives/Combined pill

ii. Oral Contraceptives/Progestin only
iii. Oral Contraceptives/Extended Continuous
iv. Patch
v. Vaginal Contraceptive Ring
vi. Emergency contraception

3. Available over the counter (OTC) :(For OTC contraception, a written prescription order must be provided for Sanford Health Plan to cover at 100% (no charge), even though no prescription order is required for the OTC purchase of the drug and/or supply)
    i. Sponge
    ii. Barrier methods: includes Diaphragm and cervical cap fitting and purchase.
    iii. Female Condom
    iv. Spermicide (generic only)

- Sanford Health Plan will continue to utilize reasonable medical management techniques, and impose cost sharing on some items and services to encourage Members to use specific items and services within the chosen contraceptive method.
- Formulary generic contraceptives are covered at 100% (no charge), regardless of how the contraceptive is delivered or dispensed. This coverage includes but is not limited to oral contraceptives.
- If no generic equivalent exists for a Formulary brand-name contraceptive, then that contraceptive is covered at 100% (no cost) per the Affordable Care Act, for the length of the prescription.

NOTE: For Members enrolled in a High Deductible Health Plan, prescription drugs are subject to Deductible and Coinsurance amounts, unless the medication or drug dispensed is covered by the Contract at 100% (no charge).

3.1.12 FOOT CARE SERVICES

- Routine foot care covered for Members with diabetes only.
- **NOTE**: See Section on Orthotic and prosthetic devices for information on podiatric shoe inserts

3.1.13 HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES)

Coverage is limited to diagnostic testing and treatment related to illness or injury only.

- Benefit is limited to one hearing aid, per ear, per Adult Member, every five (5) years, in alignment with Medical Necessity and Sanford Health Plan guidelines with prior approval *(certification required)*.
- Benefit is limited to one hearing aid, per ear, per child, every three (3) years, in alignment with Medical necessity and Sanford Health Plan guidelines. Pediatric (child) hearing coverage services for Members through the age eighteen (18).

3.1.14 HOME HEALTH SERVICES

The following are covered if approved *(certification required)* by Sanford Health Plan in lieu of a Hospital or Skilled Nursing Facility stay:

- part-time or intermittent care by a RN or LPN/LVN
- part-time or intermittent home health aide services for direct patient care only

- physical, occupational, speech, inhalation, and intravenous therapies up to the maximum benefit allowable
- medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Member were Hospitalized

NOTE: Member must be home-bound to receive home health services. Benefit limited to ***40 visits in a Calendar Year*** and does not include meals, custodial care or housekeeping. One (1) home health visit constitutes four (4) hours of nursing care.

3.1.15 IMPLANTS/STIMULATORS

- Implants and Stimulators prescribed by an attending Practitioner and/or Provider and are Medically Necessary are covered. Limitations per medical appropriate guidelines apply (available upon request).
- The following Implants/Stimulators may be covered with prior approval *(certification*);
  - Bone Growth (external)
  - Cochlear Implant (Device and Procedure)
  - Deep Brain Stimulation
  - Gastric Stimulator
  - Insertion, Removal, and Revisions of all Implants
  - Spinal Cord Stimulator (Device and Procedure)
  - Vagus Nerve Stimulator

3.1.16 INFERTILITY BENEFITS

SHP covers testing for the diagnosis of infertility. Coverage for testing includes, but is not limited to:

- Screenings for assessment of polycystic ovarian syndrome (PCOS) (limit of 1 per calendar year)
- Screenings for stimulations of ovarian reserves and ovarian functions(limit of 1 per screening per calendar year)
- Semen Analysis (limit of 2 per calendar year)
- Sonogram (limit of 1 per calendar year)
- Transvaginal ultrasound for structural evaluation (limit of 1 per calendar year)

3.1.17 LAB, X-RAY AND OTHER DIAGNOSTIC TESTS

Coverage includes, but is not limited to, the following

- Blood tests
- Urinalysis
- Non-routine Pap tests
- Non-routine PSA tests
- Pathology
- X-rays
- PET Scans
- DEXA Scans
- Non-routine mammograms
- CT Scans/MRI

- Ultrasound
- Electrocardiogram (EKG)
- Electroencephalography (EEG)

3.1.18 ONCOLOGY TREATMENT BENEFITS

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

- Radiation Therapy.
- Chemotherapy, regardless of whether the Member has separate prescription drug benefit coverage.
  - The same cost-sharing amounts apply for intravenously administered or injected cancer chemotherapy agents as for prescribed, orally-administered, anticancer medications used to kill or slow the growth of cancerous cells

- ### 3.1.19 NEWBORN CARE BENEFITS

A newborn is eligible to be covered from birth. Members must enroll the newborn within *thirty-one (31)* days of the infant's birth. If your benefit plan requires an additional payment for each Dependent, Sanford Heath Plan is entitled to all Service Charge payments due from the date of the newborn's birth until the date you notify Sanford Health Plan of the birth. Sanford Health Plan may withhold payment of any health benefits until all required Service Charge payments you owe are paid. For more information, see Section 1 on Enrollment and *When Dependent Coverage Begins.*

We cover care for the enrolled newborn child from the moment of birth including care and treatment for illness, injury, premature birth and medically diagnosed congenital defects and birth abnormalities (Please refer to "Reconstructive Surgery" in Section 3.2 for coverage information on correcting congenital defects).

3.1.20 NUTRITIONAL COUNSELING

Nutritional Counseling coverage is limited to 12 visits per calendar year.

3.1.21 ORTHOTIC AND PROSTHETIC DEVICES

Note: Select items may require prior approval *(certification*). For up to date information, please refer to https://www.sanfordhealthplan.org/members/prior-authorization

- Adjustments and/or modification to the prosthesis required by wear/tear or due to a change in Member's condition or to improve the function are eligible for coverage and do not require Prior Authorization.
- Cranial Prosthesis, including wigs up to $200 (limited to one per benefit period). .
- Devices permanently implanted that are not Experimental or Investigational Services such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. *This is a DME that requires Certification*
- Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Includes *two (2)* external prosthesis per Calendar Year and *six (6)* bras per Calendar Year. For double mastectomy: coverage extends to *four (4)* external prosthesis per Calendar Year and *six (6)* bras per Calendar Year. These do not require prior authorization.
- Prosthetic limbs, sockets and supplies, and prosthetic eyes. *This is a DME that requires Certification*

- Repairs necessary to make the prosthetic functional are covered and do not require authorization. The expense for repairs is not to exceed the estimated expense of purchasing another prosthesis.

NOTE: Internal prosthetic devices are paid as Hospital benefits; see Section 3.2 for payment information. Insertion of the device is paid under the surgery benefit.

3.1.22 OTHER TREATMENT THERAPIES NOT SPECIFIED ELSEWHERE

- Inhalation Therapy
- Pheresis Therapy

3.1.23 PEDIATRIC (CHILD) HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES)

Not Covered

3.1.24 PEDIATRIC (CHILD) VISION SERVICES

Not Covered

3.1.25 PHENYLKETONURIA (PKU) AND AMINO ACID-BASED ELEMENTAL ORAL FORMULAS COVERAGE BENEFITS

- Testing, diagnosis and treatment of Phenylketonuria;
  - Dietary management and foods, formulas, case management, intake and screening, assessment, comprehensive care planning, and service referral(s).
- Coverage of amino acid-based elemental oral formulas includes:
  - Amino acid-based elemental oral formulas may be considered Medically Necessary when ordered by a practitioner for diagnosed cases of cystic fibrosis, amino acid, organic acid, and fatty acid metabolic and malabsorption disorders.
  - Amino acid-based elemental oral formulas may be considered Medically Necessary when ordered by an allergist or gastroenterologist for diagnosed cases of IgE mediated allergies to food proteins; food protein-induced enterocolitis syndrome; eosinophilic esophagitis; eosinophilic gastroenteritis; or eosinophilic colitis.
  - Coverage for medical foods and low-protein modified food products determined by a practitioner to be Medically Necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.
  - Coverage of amino acid-based elemental formulas for patients diagnosed with an IgE mediated condition is limited to age five years and under.
  - The covered formula must contain 100% free amino acids as the protein source

3.1.26 PHYSICAL, CARDIAC SPEECH AND OCCUPATIONAL THERAPIES

Outpatient rehabilitative therapies directed at improving physical functioning of the Member, which are expected to provide significant improvement within two (2) months, as certified on a prospective basis. Services must be provided in accordance with a prescribed plan of treatment ordered by a Practitioner and/or Provider. Benefits are not available for Maintenance Care. Coverage includes:

- Physical Therapy; limited to thirty (30) visits per therapy (condition) per calendar year.

- Occupational Therapy; limited to thirty (30) visits per therapy (condition) per calendar year.
- Speech Therapy limited to thirty (30) visits per therapy (condition) per calendar year.
    - Speech therapy services must be related to a specific illness, injury, or impairment, and involve the mechanics of phonation, articulation, or swallowing. Services must be provided by a licensed or certified speech pathologist.
- Habilitative Therapy; limited to thirty (30) visits per therapy (condition) per calendar year.
    - Includes the management of limitations and disabilities and services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function.
- Includes One-to-one water therapy
- Physical therapy and Vitamin D supplements with a prescription order are covered at 100% (no cost) for Members ages 65 and older who are at increased risk for falls. Benefits are subject to Medical Necessity.

3.1.27 PRENATAL AND MATERNITY SERVICES

NOTE: Due to the inability to predict admission, you or your Practitioner and/or Provider are encouraged to notify us of your expected due date when the pregnancy is confirmed. You are also encouraged to notify us of the date of scheduled C-sections when it is confirmed. In-Network Participating Practitioner and/or Providers or other health care providers do not need to obtain authorization for prescribing a length of stay of up to 48 hours for a vaginal delivery or of up to 96 hours for a cesarean birth. However, to use certain providers or facilities, or to reduce out-of-pocket costs, precertification may be required.

All pre or post-natal care falling outside the routine care limits below will be covered per applicable cost sharing based on a Member's Plan. Routine prenatal care (as outlined below) will be covered at 100%:

- Anemia screening; -Limit of One (1) per pregnancy
- Blood type- Limit of One (1) per pregnancy
- Complete blood count (CBC) - Limit of Two (2) per pregnancy
- Depression screening- Limit of One (1) per pregnancy
- Group B streptococci (GBS) - Limit of One (1) per pregnancy
- Hepatitis B screening; -Limit of One (1) per pregnancy
- Hepatitis C Screening - Limit of One (1) per pregnancy
- Human immunodeficiency virus (HIV, during pregnancy) - Limit of One (1) per pregnancy
- Office visits related to a confirmed pregnancy while member is pregnant
- Preeclampsia prevention;
- Rh (Rhesus) incompatibility screening: first pregnancy visit and 24-28 weeks gestation;
- Rubella Screening - Limit of One (1) per pregnancy
- Screening for gestational diabetes mellitus during pregnancy – Testing includes a screening blood sugar followed by a glucose tolerance test if the sugar is high; -Limit of One (1) per pregnancy
- Screening for sexually transmitted infections (STIs, during pregnancy) - Limit of One (1) per pregnancy
- Tuberculosis (TB) - Limit of One (1) per pregnancy
- Ultrasound (2D) - Limit of Two (2) per pregnancy
- Urine culture- Limit of One (1) per pregnancy
- Urine dipstick or Urinalysis- Limit of Nine (9) per pregnancy

Breastfeeding support, supplies and counseling are covered in the following manner:

- Sanford Health Plan will allow one breast pump (electric or manual) per pregnancy.
- Replacement tubing, breast shields, and splash protectors are also covered.
- Bottles, breast milk storage bags and supplies related to bottles are NOT covered.
- Pumps and supplies are covered only when obtained from a Sanford Health Plan In-Network Participating Practitioner and/or Provider. This does NOT include drugstores or department stores.

In addition to pumps, consultation with a lactation (breastfeeding) specialist is also covered.

Newborns' and Mothers' Health Protection Act Disclosure

The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of forty-eight (48) hours for a vaginal delivery to a minimum of ninety-six (96) hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Practitioner, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If the inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by In-Network Participating Practitioner and/or Providers competent in postpartum care and newborn assessments within forty-eight (48) hours after discharge to verify the condition of the mother and newborn. If such an inpatient stay lasts longer than the minimum required hours, Sanford Health Plan will not set the level of benefits or out-of-pocket costs so that the later portion of the stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

NOTE: We encourage you to participate in our Healthy Pregnancy Program; Call (888) 315-0884 (toll-free) or TTY/TDD: (877) 652-1844 (toll-free) to enroll.

3.1.28 PREVENTIVE CARE, ADULTS & CHILDREN

The following preventive services, received from In-Network Participating Practitioner and/or Provider are covered without payment of any deductible, copayment, or coinsurance requirement that would otherwise apply:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009. Which includes;
    a. One baseline mammogram for women who are at least thirty-five (35) years of age but less than forty (40) years of age, and one mammogram every year, or more frequently if ordered by a physician, for women who are at least forty (40) years of age;
    b. One prostate screening for asymptomatic men aged fifty (50) and over, African American men aged forty (40) and over, and men aged forty (40) and over with a family history of prostate cancer.
2. Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Member involved;
3. With respect to covered persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

4. With respect to covered persons who are women, such additional preventive care and screenings not described in paragraph (1) above as provided for in comprehensive guidelines supported by the Health Resources and Services Administration. You do not need prior authorization from Sanford Health Plan or any other person in order to obtain access to obstetrical and/or gynecological care through an In-Network Participating Practitioner and/or Provider.

The above is an overview of preventive services covered by Sanford Health Plan. As recommendations change, your coverage may also change. To view Sanford Health Plan's Preventive Health Guidelines, visit www.sanfordhealthplan.com/memberlogin. You may also request a copy by calling Customer service at (800) 752-5863 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free).

3.1.29 PRIVATE DUTY NURSING

Not Covered

3.1.30 TELEHEALTH, E-VISIT, AND VIDEO VISITS BENEFIT

Per Sanford Health Plan guidelines (available upon request), telemedicine, e-visit, and video visit services is covered and available through a secured interactive audio, video, or email connection.

- Access to services may be done through a smart phone, tablet or computer.
- For non-Emergency Health Conditions, coverage under this section includes but is not limited to diagnosis, consultation, or treatment.
- Telemedicine, e-visit, and video visit services must be rendered by an In-Network Participating Practitioner and/or Provider Approved by Sanford Health Plan.

The following services are covered pursuant to Sanford Health Plan's medical coverage guidelines:

- Telemedicine Services: live, interactive audio and visual transmissions of a physician-patient encounter from one site to another, using telecommunications technologies. Services may include tele-monitoring of patient status and transmittal of the information to another Provider.
- E-visits: email, online medical evaluations where Providers interact with Members through a secured email.
- Video Visits: virtual visits where Providers interact with Members through online access via mobile smart phone, tablet or computer.

NOTE: Charges for telehealth, e-visit, and video visit services may be subject to applicable Deductible and/or Cost Sharing Amounts; see your SBC for details. Cost Sharing for these services does not include any related pharmacy charges. Prescriptions (if any) are covered separately under the prescription drug benefit. Charges for prescribed medication/drugs are listed in your SBC.

3.1.31 TOBACCO CESSATION TREATMENT BENEFITS

Tobacco cessation treatment coverage is as follows:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force when received from an In-

Network provider are covered without payment of any Deductible, Copay, or Coinsurance requirement that would otherwise apply.

- Tobacco cessation treatment includes:
    - Screening for tobacco use; and
    - At least two (2) tobacco cessation attempts per year (for Members who use tobacco products).
        - Covering a cessation attempt is defined to include coverage for:
            - Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization, and
            - One ninety (90) day treatment regimen of Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a Health Care Provider without prior authorization.

3.2 SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY

Here are some important things you should keep in mind about these benefits:

- *Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Policy and are payable only when we determine they are Medically Necessary.*
- *In-Network Participating Practitioner and/or Providers must provide or arrange your care and you must be hospitalized in a Network Facility.*
- *Mental Health and Substance Use Disorder benefits provided by a Hospital or other Facility are outlined in Section 3.4).*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *YOUR PRACTITIONER AND/OR PROVIDER MUST GET CERTIFICATION OF SOME OF THESE SERVICES.*

3.2.1 ADMISSIONS

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits.

The following Hospital Services are covered:

- Room and board
- Critical care services
- Use of the operating room and related facilities
- General Nursing Services, including special duty Nursing Services if approved by the Plan
- The administration of whole blood and blood plasma is a Covered Service. The purchase of whole blood and blood components is not covered unless such blood components are classified as drugs in the United States Pharmacopoeia.
- Special diets during Hospitalization, when specifically ordered
- Other services, supplies, biologicals, drugs and medicines prescribed by a Practitioner and/or Provider during Hospitalization

NOTE: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the Hospital up to 48 hours after the procedure.

3.2.2 ANESTHESIA

SHP covers services of an anesthesiologist or other certified anesthesia Provider.

3.2.3 HOSPICE CARE

- A Member may elect to receive hospice care, instead of the traditional Covered Services provided under the Plan, when the following circumstances apply:
    - The Member has been diagnosed with a terminal disease and has a life expectancy of six (6) months or less;
    - The Member has chosen a palliative treatment focus (i.e. emphasizing comfort and support services rather than treatment attempting to cure the disease or condition);and
    - The Member continues to meet the terminally ill prognosis as reviewed by the Plan's Chief Medical Officer over the course of hospice care.
- The following Hospice Services are Covered Services:
    - Admission to a hospice Facility, Hospital, or Skilled Nursing Facility for room and board, supplies and services for pain management and other acute/chronic symptom management

- Part-time or intermittent nursing care by a RN, LPN/LVN, or home health aide for Member care up to eight (8) hours per day
- Social services under the direction of an In-Network Participating Practitioner and/or Provider
- Psychological and dietary counseling
- Physical or occupational therapy, as described under Section 3.1
- Consultation and Case Management services by an In-Network Participating Practitioner and/or Provider
- Medical supplies, DME and drugs prescribed by an In-Network Participating Practitioner and/or Provider Expenses for In-Network Participating Practitioner and/or Providers for consultant or Case Management services, or for physical or occupational therapists, who are not Group Members of the hospice, to the extent of coverage for these services as listed in Section 3.1, but only where the hospice retains responsibility for the care of the Member

Respite Care:

- Fifteen (15) days per lifetime for inpatient hospice respite care,
- Fifteen (15) days per lifetime for outpatient hospice respite care.
- Must be used in increments of not more than five (5) days at a time.

3.2.3 ORAL AND MAXILLOFACIAL SURGERY

NOTE: Some services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.org/members/prior-authorization

- Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.* .
  - Care must be received within *six (6)* months of the occurrence
- Orthognathic Surgery per Sanford Health Plan guidelines. *This is an Outpatient Surgery that requires Certification*
  - Associated radiology services are included
  - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
  - Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
  - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
  - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
  - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
    - Splint limited to one (1) per Member per benefit period.
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
  - is a child age five (5) or older- *(Certification is not required for children under 5)*; or
  - is severely disabled or otherwise suffers from a developmental disability; or

- has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

3.2.4 OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.org/members/prior-authorization)

Health Care Services furnished in connection with a surgical procedure performed at an In-Network Participating Surgical Center include:

- Outpatient Hospital surgical center
- Outpatient Hospital services such as diagnostic tests
- Ambulatory Surgical Center (same day surgery)

3.2.5 RECONSTRUCTIVE SURGERY

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.org/members/prior-authorization)

- Surgery to restore bodily function or correct a deformity caused by illness or injury
- Surgery that is incidental to or follows surgery resulting from injury, sickness or other diseases of the involved part or when such service is performed on a covered dependent child because of congenital disease or anomaly which has resulted in a functional defect as determined by the attending physician.
- If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). Coverage for mastectomy related benefits will be provided in a manner determined in consultation with the attending physician and Member. Coverage will be provided for reconstructive breast surgery and physical complications at all stages of a mastectomy, including lymphedema for those Members who had a mastectomy resultant from a disease, illness, or injury. For single mastectomy: coverage extends to the non-affected side to make it symmetrical with the affected breast post-surgical reconstruction. Breast prostheses and surgical bras and replacements are also covered (see *Orthotic and Prosthetic devices* in this Section). Deductible and Coinsurance applies as outlined in your Summary of Benefits and Coverage.

3.2.6 SKILLED NURSING CARE FACILITY BENEFITS

NOTE: Some services require Certification; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.org/members/prior-authorization)

- Skilled Nursing Facility Services are covered if approved by the Plan in lieu of continued or anticipated Hospitalization. The following Skilled Nursing Facility Services are covered when provided through a state-licensed nursing Facility or program:
    - Skilled nursing care, whether provided in an inpatient skilled nursing unit, a Skilled Nursing Facility, or a subacute (swing bed) Facility
    - Room and board in a skilled nursing Facility
    - Special diets in a Skilled Nursing Facility, if specifically ordered

Skilled nursing Facility care is limited to ***thirty (30) days in a consecutive twelve (12) month period***. Skilled nursing care in a Hospital shall be covered if the level of care needed by a Member has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the Hospital or in another Hospital or Facility within a thirty-mile (30) radius of the Hospital

3.2.7 TRANSPLANT SERVICES

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.org/members/prior-authorization)

To be eligible for coverage, Transplants must meet United Network for Organ Sharing (UNOS) criteria and/or Sanford Health Plan Medical Criteria. Transplants must be performed at contracted Centers of Excellence or otherwise identified and accepted by Sanford Health Plan as qualified facilities.

Coverage is provided for transplants according to our medical coverage guidelines (available upon request) for the following services:

- Bone marrow or stem cell acquisition and short term storage during therapy for a Member with a covered illness
- Drugs (including immunosuppressive drugs)
- Living donor transplant-related complications for sixty (60) days following the date the organ is removed, if not otherwise covered by donor's own health benefit plan, by another group health plan or other coverage arrangement
- Organ acquisition costs including:
    - For cadaver donors: operating room services, intensive care cost, preservation supplies (perfusion materials and equipment), preservation technician's services, transportation cost, and tissue typing of the cadaver organ
    - For living donors: organ donor fees, recipient registration fees, laboratory tests (including tissue typing of recipient and donor), and Hospital services that are directly related to the excision of the organ
- Post-transplant care and treatment
- Pre-operative care
- Psychological testing
- Second Opinions
    - SHP will notify the Member if a second opinion is required at any time during the determination of benefits period. If a Member is denied a transplant procedure by the transplant facility, the Plan will allow them to go to a second transplant facility for evaluation. If the second facility determines, for any reason, that the Member is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third transplant facility accepts the Member for the procedure.
- Short-term storage of umbilical cord blood for a Member with a malignancy undergoing treatment when there is a donor match.
- Supplies (must be Prior Authorized)
- Transplant procedure, Facility and professional fees

3.3 EMERGENCY SERVICES/ACCIDENTS

Here are some important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.

3.3.1 BENEFIT DESCRIPTION

What is an Emergency Medical Condition?
An Emergency Medical Condition is the sudden and unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.

What is an urgent care situation?
An urgent care situation is a degree of illness or injury, which is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours, such as stitches for a cut finger.

If an urgent care situation occurs, Members should contact their Primary Care Physician immediately, if one has been selected, and follows his or her instructions. A Member may always go directly to an urgent care or after-hours clinic.

We cover worldwide emergency services necessary to screen and stabilize Members without Certification in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed.

3.1.2 EMERGENCY WITHIN OUR SERVICE AREA

Emergency services from Out-of-Network Providers will be covered at the same benefit and Cost Sharing level as services provided by In-Network Providers. If the Plan determines the condition did not meet Prudent Layperson definition of an emergency, then the Out-of-Network Deductible and Coinsurance amounts will apply and the Member is responsible for charges above the reasonable cost.

If an Emergency Condition arises, Members should proceed to the nearest emergency Facility that is an In-Network Participating Practitioner and/or Provider. If the Emergency Condition is such that a Member cannot go safely to the nearest participating emergency Facility, then the Member should seek care at the nearest emergency Facility.

The Practitioner and/or Provider must notify the Plan and the Member's Primary Care Practitioner and/or Provider, if one has been selected, as soon as reasonably possible, and no later than forty-eight (48) hours after physically or mentally able to do so.

We cover emergency services necessary to screen and stabilize members without pre-Certification in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. With respect to care obtained from a Non-Participating Provider within the Service Area, we cover emergency services necessary to screen and stabilize a Member, and may not require Prospective (pre-service) Review of such services if a

Prudent Layperson would have reasonably believed that use of an In-Network Participating Practitioner and/or Provider would result in a delay that would worsen the emergency; or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

If a Member is admitted to a Non-Participating or Out-of-Network Provider, we will contact the admitting Practitioner and/or Provider to determine Medical Necessity and a plan for treatment. In some cases, where it is medically safe to do so, the Member may be transferred to a Hospital that is an In-Network Participating Practitioner and/or Provider

3.3.3 EMERGENCY OUTSIDE OUR SERVICE AREA

If an Emergency occurs when traveling outside of the Service Area, Members should go to the nearest emergency Facility to receive care. The Member or a designated relative or friend must notify us and the Member's Primary Care Practitioner and/or Provider, if one has been selected, as soon as reasonably possible, and no later than forty-eight (48) hours after physically or mentally able to do so.
Coverage will be provided for Emergency Medical Conditions outside of the Service Area (at the In-Network benefit level) unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

If an Urgent Care Situation occurs when traveling outside of the Service Area, Members should contact their Primary Care Practitioner and/or Provider immediately, if one has been selected, and follow his or her instructions. If a Primary Care Practitioner and/or Provider has not been selected, the Member should contact us and follow our instructions. Coverage will be provided for urgent care situations outside the Service Area at the In-Network level unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

NOTE: Unless care is received from an In-Network Participating Practitioner and/or Provider, coverage will be at the Out-of-Network benefit level for non-Emergency Medical Conditions or non-urgent care received when a Member is traveling or studying outside the Service Area

3.3.4 AMBULANCE AND TRANSPORTATION SERVICES

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.org/members/prior-authorization)

Transportation by professional ground ambulance, air ambulance, or on a regularly scheduled flight on a commercial airline when transportation is:

- Medically Necessary; and
- To the nearest In-Network Participating Practitioner and/or Provider equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by the Plan.

3.4 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

Here are some important things to keep in mind about these benefits:

- *All benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *YOUR PRACTITIONER AND/OR PROVIDER MUST GET CERTIFICATION OF SOME OF THESE SERVICES. See the benefits description below.*

3.4.1 MENTAL HEALTH BENEFITS

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limitations that apply to Sanford Health Plan's mental health and/or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. In addition, mental health and substance use disorder benefits are not subject to separate cost sharing requirements or treatment limitations. Mental health and substance use disorders are covered consistent with generally recognized independent standards of current medical practice, which include the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD).

Coverage is provided for mental health conditions which current prevailing medical consensus affirms substantially impairs perception, cognitive function, judgment, and/or emotional stability, and limits the life activities of the person with the condition(s). This includes but is not limited to the following conditions: schizophrenia; schizoaffective disorders; bipolar disorder; major depressive disorders (single episode or recurrent); obsessive-compulsive disorders; attention-deficit/hyperactivity disorder; autism spectrum disorders; post-traumatic stress disorders (acute, chronic, or with delayed onset); and anxiety disorders that cause significant impairment of function.

Mental health benefits are covered with the same Cost Sharing and restrictions as other medical/surgical benefits under the Contract. Coverage for mental health conditions includes:

- Diagnostic tests
- Electroconvulsive therapy (ECT)
- Inpatient services, including Hospitalizations
- Intensive Outpatient Programs
- Medication management
- Outpatient Professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, or other qualified mental health professionals
- Partial Hospitalization

NOTE: Certification is required for the following; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.org/members/prior-authorization)

- All Inpatient services provided by a Hospital, Residential Treatment Facility, or other alternate care facility

3.4.2 APPLIED BEHAVIOR ANALYSIS FOR TREATMENT OF AUTISM SPECTRUM DISORDER

Applied Behavior Analysis (ABA) is a covered service for the treatment of Members diagnosed with Autism Spectrum Disorder.

NOTE: Certification is required; failure to get Certification may result in a reduction or denial of benefits.

1. Member must be diagnosed with Autism Spectrum Disorder by a Provider and/or Practitioner qualified to diagnose the condition.
2. ABA as behavioral health treatment is expected to result in the achievement of specific improvements in the Member's functional capacity of their autism spectrum disorder, subject to Plan medical policy and medical necessity guidelines
3. ABA services are only covered when provided by a licensed or certified practitioner as defined by law.
4. Coverage of ABA is subject to preauthorization, concurrent review, and other care management requirements.
5. Limits are subject to the Plan's medical management policies and determinations of Medical Necessity.
    a. This coverage would be subject to the following limits:
        - Through age 6: $36,000
        - Age 7-13: 900 $25,000
        - Age 14-18: $12,500

3.4.3 SUBSTANCE USE DISORDER BENEFITS

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limitations that apply to the mental health and/or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. In addition, mental health and substance use disorder benefits are not subject to separate Cost Sharing requirements or treatment limitations. Mental health and substance use disorders are covered consistent with generally recognized independent standards of current medical practice, which include the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD).

Substance use disorder benefits are covered with the same Copays, Deductibles, Coinsurance factors, and restrictions as other medical/surgical benefits under the Plan. Coverage for substance use disorders includes:

- Addiction treatment, including for alcohol, drug-dependence, and gambling issues
- Inpatient services, including Hospitalization
- Outpatient professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, Licensed Chemical Dependency Counselors, or other qualified mental health and substance use disorder treatment professionals
- Partial Hospitalization
- Intensive Outpatient Programs

NOTE: Certification is required for the following; failure to get Certification will result in a reduction or denial of benefits. (Refer to Services requiring Certification at https://www.sanfordhealthplan.org/members/prior-authorization)

- All Inpatient services provided by a Hospital, Residential Treatment Facility, or other alternate care facility

3.5 OUTPATIENT PRESCRIPTION DRUG BENEFITS

Here are some important things to keep in mind about these benefits:

- *Always refer to your Summary of Benefits (SBC), Formulary and other plan documents for specific details on your coverage.*
- *SHP covers prescribed drugs and medications, as described in this Section and in your Summary of Benefits/Formulary documents.*
- *All benefits are subject to definitions, limitations and exclusions listed in this document and are only payable when considered Medically Necessary.*
- *You must receive prior approval (authorization) for some medications. See the Summary of Benefits and Formulary for information.*

3.5.1 BENEFIT DESCRIPTION

- You must fill the prescription at an In-Network Participating Pharmacy. If you choose to go to a Non-Participating or Out-of-Network Pharmacy, you will be responsible for all (100%) of the costs of the prescription to the pharmacy. Specialty drugs must be obtained through the Plan's contracted specialty pharmacy. North Dakota members may utilize any pharmacy to fill specialty medications.
- To fill a prescription, you must present your ID card to your pharmacy, if you do not, you will be responsible for all (100%) of the costs of the prescription to the pharmacy.
- Sanford Health Plan uses a formulary: a list of prescription drug products, which are covered by the Plan for dispensing to Members when appropriate. The formulary will be reviewed regularly, and medications may be added or removed from the Formulary throughout the year. The Plan will notify you of the changes as they occur. For a copy of the Plan Formulary, contact Pharmacy Management at (855) 305-5062 | TTY/TDD: (877) 652-1844 (toll-free) or log in to your Member Portal at www.sanfordhealthplan.com/memberlogin.
- Sanford Health Plan reserves the right to maintain a drug listing of medications that are not available/excluded for coverage per Plan medical necessity and limitation guidelines. Payment for excluded medications will be the Member's responsibility in full. Members may request an appeal (review of an Adverse Determination) based on medical necessity for Non-Covered medications. For details, refer to the appeals section of this Certificate of Coverage.
- Sanford Health Plan will use appropriate Pharmacists and Practitioner and/or Providers to review formulary exception requests and promptly grant an exception to the formulary for a Member when that the prescriber indicates:
    - the Formulary drug causes an adverse reaction in the Member;
    - the Formulary drug is contraindicated for the Member; or
    - the prescription drug must be dispensed as written to provide maximum medical benefit to the Member.
- **NOTE**: To request a Formulary exception, please call Pharmacy Management at (855) 305-5062 | TTY/TDD: (877) 652-1844 (toll-free) fax requests to (701) 234-4568 or send a request by logging into the provider portal at www.sanfordhealthplan.com/memberlogin Members must first try formulary medications before an exception to the formulary will be made unless the prescriber and the plan determine that use of the formulary drug may cause an adverse reaction or be contraindicated for the Member. If an exception is granted, coverage of the non-formulary drug will be provided for the

duration of the prescription, including refills. See Pharmaceutical Review Requests and Exception to the Formulary Process in Section 2 for details.

- With certain medications, the Plan requires a trial of first-line medications, typically generics, before more expensive name brand medications are covered. If the desired clinical effect achieved or a side effect is experienced, then a second line medication may be tried. If a step therapy rule is not met at the pharmacy, coverage will be determined by Prior Authorization (pre-approval) Review. Request Prior Authorization by contacting Pharmacy Management toll free at (855) 305-5062| TTY/TDD: (877) 652-1844. Refer to the Formulary for a complete list of medications that require step therapy.
- To be covered by the Plan, certain medications require prior authorization (pre-approval) to ensure medical necessity. This can be in the form of written or verbal certification by a prescriber. To request certification, contact Pharmacy Management at (855) 305-5062 | TTY/TDD: (877) 652-1844 or fax requests to (701) 234-4568. Refer to the formulary for a complete list of medications that require Prior Authorization.
- Certain medications have a quantity limit to ensure the medication is being used as prescribed and the member is receiving the most appropriate treatment based on manufacturer's safety and dosing guidelines. Refer to your formulary for a complete list of medications with quantity limits.
- Prescriptions will be filled for up to a thirty (30) day supply per copay (or less, if prescribed) at one time (unless otherwise approved by the Plan).
- Prescription refills will be covered when 75% of your prescription has been used based on your prescription duration. The 75% threshold accumulates the amount of medication used in the past 180-days to determine the date of the next refill.
- Prescription medications identified as maintenance medications may be filled for a ninety (90) day supply, but three (3) Copays will apply.
- Specialty medications can be filled up to a thirty (30) day supply per copay (or less, if prescribed) at one time (unless otherwise approved by the Plan).
- If you traveling on vacation and need an extra supply of medication, you may request a "vacation override" to receive up to a three (3) month's supply of medication. Vacation supplies are limited to the time period that the Member is enrolled in the plan and one vacation override per medication per calendar year. Please contact Pharmacy Management at (855) 305-5062| TTY/TDD: (877) 652-1844 to request a vacation override.
- If you receive a brand name drug when there is an equivalent generic alternative available, you will be required to pay a brand penalty. The brand penalty consists of the price difference between a brand name drug and the generic equivalent, in addition to applicable cost sharing (copay and/or deductible/coinsurance) amounts. Brand penalties do not apply to your deductible or maximum out of pocket.
- For participants enrolled in a High Deductible Health Plan, the prescription drug benefit is subject to your deductible and coinsurance amounts.

3.5.2 COVERED MEDICATIONS AND SUPPLIES

To be covered by the Plan, prescriptions must be:

1. Prescribed or approved by a licensed physician, physician assistant, nurse practitioner or dentist;
2. Listed in the Plan Formulary, unless certification (authorization) is given by the Plan;

3. Provided by an In-Network Participating Pharmacy except in the event of urgent or emergent medical situations (if a prescription is filled at a Non-Participating and/or Out-of-Network Pharmacy in non-urgent or emergent medication situations, the Member will be responsible for the cost of the prescription medication in full.);
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

3.5.3 COVERED TYPES OF PRESCRIPTIONS

- Federal Legend Drugs. Any medicinal substance which bears the legend: "Caution: Federal Law prohibits dispensing without a prescription," except for those medicinal substances classified as exempt narcotics pursuant to applicable laws and regulations.
- Self-Administered medications- medications such as subcutaneous injections, oral or topical medications, or nebulized inhalation are to be obtained from a Network Pharmacy
- Medicinal substances (legally restricted medications) that may only be dispensed by a prescription, according to applicable laws and regulations
- Compounded medications are only covered when the medication has at least one ingredient that is a federal legend or state restricted drug in a therapeutic amount.
- Diabetic supplies, such as insulin, a blood glucose meter, blood glucose test strips, diabetic needles and syringes are covered when medically necessary. (See section 3.1 for Diabetic supplies, equipment, and self-management training benefits.)
- Generic oral contraceptives, Nuvaring, injections and/or devices will be covered by the Plan at 100% (no charge)

3.6 DENTAL BENEFITS

Here are some important things to keep in mind about these benefits:

- *Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.*
- *We cover Hospitalization for dental procedures only when a non-dental physical impairment exists which makes Hospitalization necessary to safeguard the health of the Member. See Section 3.2 for inpatient Hospital benefits. We do not cover the dental procedure unless it is described below.*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *YOU MUST GET CERTIFICATION OF THESE SERVICES.*

3.6.1 BENEFIT DESCRIPTION

NOTE: The following benefits are Outpatient Surgeries, Service, of DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services that Require Prospective Review/Prior Authorization (Certification) in Section 2.)

- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
    - Services for the Treatment and Diagnosis of TMJ/TMD subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
    - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers and is Medically Necessary pursuant to Sanford Health Plan's medical coverage guidelines.
    - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
        - Splint limited to one (1) per Member per benefit period.
- Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth, as long as the Member was covered under this Contract during the time of the injury or illness causing the damage. This is an Outpatient Surgery that requires Certification.
    - Care must be received within six (6) months of the occurrence
    - Extractions when medically necessary because of injury, accident, or cancer when Sanford Health Plan internal guidelines are met
    - Associated radiology services are included
    - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
    - Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service that requires Certification.*
    - is a child under age five (5); or
    - is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician; or

has a medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

3.6.2 PEDIATRIC (CHILD) DENTAL CARE

Not covered

3.7 OUT-OF-NETWORK BENEFITS

Here are some important things to keep in mind about these benefits:

- *All benefits are subject to the definitions, limitations and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage..*

Out-of-Network Coverage means Covered Services that do not fit the definition of In-Network Coverage as set forth in Section 2.

Out-of-Network Coverage means non-emergency and/or non-urgent Covered Services that are received from the following:

- A Non-Participating Provider when appropriate access to an In-Network Participating Practitioner and/or Provider is available;
- A Non-Participating Provider or Out-of-Network Participating Provider when an In-Network Participating Practitioner and/or Provider has not recommended the referral and Sanford Health Plan has not authorized the referral to the Non-Participating Provider;
- A Participating Provider outside of the Service Area when a Participating Provider has not recommended the referral and Sanford Health Plan has not authorized the referral to the Participating Provider outside the Service Area.

You may choose to obtain benefits at our Out-of-Network benefits level by seeking care from Non-Participating or Out-of-Network Providers, except for the benefits listed below under "What is not covered." When you obtain covered non-emergency medical treatment from a Non-Participating or Out-of-Network Provider without authorization from us, you are subject to the Deductibles, Coinsurance and maximum benefit stated in your Summary of Benefits and Coverage and Summary of Pharmacy Benefits.

All Out-of-Network services are subject to Maximum Allowed Amount. As indicated in the Summary of Benefits and Coverage, for Out-of-Network Coverage, the Plan will pay a percentage of the Maximum Allowed Amount after credit is given for payment of the applicable Copays, Deductibles, and Coinsurance; provided that the Plan determines the billed charges are Reasonable. If the Plan determines that the billed charges are not reasonable, the Plan will only pay a percentage of the Maximum Allowed Amount. Percentage amounts are indicated on the Summary of Benefits and Coverage.

Members who live outside of the Service Area must use the Participating Providers as indicated on the Member Welcome Letter enclosed with the Member Identification Card. Members who live outside the Service Area will receive Identification Cards that display their network logo along with instructions on how to access this Network. If Member chooses to go to a Non-Participating or Out-of-Network Provider when access is available, claims will be paid at the Out-of-Network Benefit Level.

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SECTION 4
LIMITED AND NON-COVERED SERVICES

This section describes services that are subject to limitations or NOT covered under this Contract. The Plan is not responsible for payment of non-covered or excluded benefits.

4.1 GENERAL MEDICAL EXCLUSIONS

1. Abdominoplasty
2. Acupuncture, unless covered under Medicare Guidelines for treatment of lower back pain
3. Admissions to Hospitals performed only for the convenience of the Member, the Member's family or the Member's Practitioner and/or Provider
4. Air conditions, air filters, or other products to eradicate dust mites
5. All other hearing related supplies, purchases, examinations, testing or fittings
6. Alternative treatment therapies including, but not limited to: acupressure, massage therapy unless covered per plan guidelines under WHCRA for mastectomy/lymphedema treatment, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, sleep therapy (except for treatment of obstructive apnea), or therapeutic touch
7. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination
8. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this Certificate of Coverage
9. Any expenses related to surrogate parenting, except if Surrogate is a covered Member under this Certificate of Coverage and seeking otherwise Covered Services
10. Any form of allergy testing and immunotherapy that is considered experimental or not FDA approved
11. Any fraudulently billed charges or services received under fraudulent circumstances
12. Any other equipment and/or supplies which the Plan determines not eligible for coverage
13. Any other services or supplies related to artificial means of conception;
14. Any services or supplies for the treatment of obesity that do not meet Sanford Health Plan's coverage guidelines, including but not limited to: dietary regimen (except as related to covered nutritional counseling); nutritional supplements or food supplements; and weight loss or exercise programs
15. Appetite suppressants and supplies of a similar nature
16. Appointment scheduling
17. Artificial organs, any transplant or transplant services not listed above
18. Autopsies, unless the autopsy is at the request of The Plan in order to settle a dispute concerning provision or payment of benefits. The autopsy will be at the Plan's expense.
19. Behavioral therapy, modification, or training
20. Blood and blood derivatives replaced by the Member
21. Charges for duplicating and obtaining medical records from Non-Participating Providers unless requested by us
22. Charges for professional sign language and foreign language interpreter services unless required by state or federal law
23. Charges for sales tax, mailing, interest and delivery
24. Charges for services determined to be duplicate services
25. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner and/or Provider or electronic consultations, unless otherwise stated in this Certificate of Coverage

26. Charges that exceed the Maximum Allowed Amount for Non-Participating Providers
27. Chiropractic manipulations for allergies
28. Clarification of simple instructions
29. Commodes and/or similar convenience items
30. Compact (portable) travel hemodialyzer system
31. Complications resulting from non-covered or denied Health Care Services.
32. Confinement Services to hold or confine a Member under chemical influence when no Medically Necessary services are provided, regardless of where the services are received (e.g. detoxification centers)
33. Consultative message exchanges with an individual who is seen in the provider's office following a video visit for the same condition, per Sanford Health Plan guidelines
34. Convalescent care
35. Cosmetic Services and/or supplies to repair or reshape a body structure not Medically Necessary and/or primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services
36. Costs related to locating organ donors
37. Coverage beyond one (1) piece of same-use equipment (e.g. mobilization, suction), unless replacement is covered under the replacement guidelines in this policy. Duplicate or back up equipment is not a covered benefit.
38. Cryogenic or other preservation techniques used in such or similar procedures;
39. Custodial care
40. Custodial or convalescent care
41. Daycare, Attendant, or Homemaker Services
42. Deluxe equipment
43. Dental appliances of any sort, including but not limited to those related to Sleep Apnea, bridges, braces, and retainers that are for cosmetic reasons and/or medically unnecessary
44. Dental care and treatment (routine or non-routine) for Members ages nineteen (19) and older including but not limited to:
    a. natural Teeth replacements including crowns, bridges, braces or implants;
    b. extraction of wisdom teeth; hospitalization for extraction of teeth;
    c. dental x-rays or dental appliances;
    d. shortening of the mandible or maxillae for cosmetic purposes;
    e. services and supplies related to ridge augmentation, implantology, and preventive vestibuloplasty; and
    f. dental appliances of any sort, including but not limited to bridges, braces, and retainers, other than for treatment of TMJ/TMD
45. Dental services not specifically listed as Covered by the Policy
46. Dental x-rays
47. Diagnosis and treatment of weak, strained, or flat feet
48. Dialysis services received by Non-Participating Providers when traveling out of the service area
49. Diet therapy (specialty foods) for allergies
50. Dietary desserts and snack items
51. Dietary surveillance and counseling
52. Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage
53. Domiciliary care or Long-Term Residential Care

54. Donor expenses for complications of transplants that occur after sixty (60) days from the date the an organ is removed, regardless if the donor is covered as a Member under this Plan or not
55. Duplicate or similar items
56. Duplicate services, including allergy testing for percutaneous scratch tests, intradermal tests, and patch tests
57. Education and training for patient self-management by a qualified, non-physician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family)
58. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to,
    a. Education on self-care or home management
    b. Educational or non-medical services for learning disabilities
    c. Educational or non-medical services for learning disabilities and/or behavioral problems, including those educational or non-medical services as provided under the Individuals with Disabilities Education Act (IDEA)
    d. Educational or non-medical services for learning disabilities or behavioral problems
59. Elective abortion services, except in cases of rape, incest, or when mother's life is endangered. Prior Authorization/certification required.
60. Expenses incurred by a Member as a donor, unless the recipient is also a Member
61. Experimental and Investigational Services not part of an Approved Clinical Trial unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies
62. Extra care costs related to taking part in an Approved Clinical Trial such as additional tests that a Member may need as part of the trial, but not Routine Patient Costs.
63. Extraction of wisdom teeth
64. First aid or precautionary equipment such as standby portable oxygen units
65. Food items for medical nutrition therapy
66. Formula and supplements available Over the Counter
67. Hair transplants or hair plugs
68. Health Care Services covered by any governmental agency/unit for military service-related injuries/diseases, unless applicable law requires primary coverage for the same
69. Health Care Services for injury or disease due to voluntary participation in a riot, unless source of injury is a result of domestic violence or a medical condition
70. Health Care Services for sickness or injury sustained in the commission of a felony, unless source of injury is a result of domestic violence or a medical condition
71. Health Care Services ordered by a court or as a condition of parole or probation, unless applicable law requires the Plan to provide coverage for the same
72. Health Care Services performed by any Provider who is a Member of the Member's immediate family, including any person normally residing in the Member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only In-Network Participating Practitioner and/or Provider in the area, the Member may be treated by that Provider provided they are acting within the scope of their practice. The Member may also go to a Non-Participating Provider and receive In-Network coverage (Section 2). If the immediate family member is not the only In-Network Participating Practitioner and/or Provider in the area, the Member must go to another In-Network Participating Practitioner and/or Provider in order to receive coverage at the In-Network level.
73. Health Care Services prohibited state or federal rule, law, or regulation
74. Health Care Services provided either before the effective date of the Member's coverage or after the Member's coverage is terminated.
75. Health Care Services received from a Non-Participating Provider, unless otherwise specified in this Contract.

76. Health Care Services required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation
77. Health Care Services that are the responsibility of a Third-Party Payor
78. Health Care Services that we determine are not Medically Necessary
79. Health services received outside of the United States that are not Medically Necessary emergency or urgent care services.
80. Hearing aids for the treatment of gradual hearing loss that occurs with aging and/or other lifestyle factors, non-implant devices, or equipment to correct hearing impairment or loss
81. Hemodialysis machine (not separately payable)
82. Home birth settings, related equipment and fees
83. Home delivered meals or laundry services
84. Home modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment
85. Home Traction Units
86. Homeopathic treatment of allergies
87. Hospitalization for extraction of teeth that is not Medically Necessary
88. Hot/cold pack therapy including polar ice therapy and water circulating devices
89. Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, waterbeds, physical fitness equipment, hot tubs, or whirlpools
90. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas
91. Hypnotism
92. Iatrogenic condition illness or injury as a result of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error. Charges related to Iatrogenic illness or injury are not the responsibility of the Member.
93. Incidental cholecystectomy performed at the time of weight loss surgery
94. Independent nursing, homemaker services
95. Infertility medication
96. Inpatient services provided at a Residential Treatment Facility if treatment is not provided at an acute level of care with 24-hour registered nursing care under the supervision of a Chief Medical Officer.
97. Installation or maintenance of any telecommunication devices or systems
98. Intermediate level or domiciliary care
99. Items which are primarily non-medical and educational in nature or for vocation, comfort, convenience or recreation
100. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics
101. Liposuction, gastric balloons, or wiring of the jaw (unless otherwise related to a covered injury or illness)
102. Long-Term Residential Care
103. Low protein modified food products or medical food for PKU to the extent those benefits are available under a Department of Health program or other state agency
104. Maintenance and service fee for capped-rental items
105. Maintenance Care that is typically long-term and by definition not therapeutically necessary
106. Maintenance Therapy
107. Male Condoms
108. Marriage counseling; pastoral counseling; financial or legal counseling; and custodial care counseling
109. Maternity classes and/or education programs
110. Meals, custodial care or housekeeping

111. Milieu therapy
112. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events. Participating Providers are not permitted to bill Members for services related to such events.
113. Newborn delivery and nursery charges for adopted Dependents prior to the adoption-bonding period
114. Non-licensed birthing assistance, such as doulas
115. Non-surgical treatments that do not meet the Plan's Medically Necessary guidelines (available upon request)
116. Nursing care requested by, or for the convenience of the Member or the Member's family (rest cures)
117. Nutritional or food supplements (services supplies and/or nutritional sustenance products or food related to enteral feeding, except when it's the sole means of nutrition)
118. Online assessment and management service provided by a qualified no physician health care professional, internet or electronic communications.
119. Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliances
120. Panniculectomy that does not meet Plan guidelines
121. Personal comfort items (telephone, television, guest meals and beds)
122. PKU dietary desserts and snack items
123. Provider-initiated e-mail
124. Provocative food testing
125. Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other Health Care Services
126. Reminders of scheduled office visits
127. Remote control devices as optional accessories
128. Removal of skin tags
129. Removal, revision or re-implantation of saline or silicone implants for: breast implant malposition; unsatisfactory aesthetic outcome; Member desire for change of implant; Member fear of possible negative health effects; or removal of ruptured saline implants that do not meet Medical Necessity criteriaFees for room and board unless Prior Authorized
130. Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness; or if lost or stolen
131. Replacement or repair of items, if the items are damaged or destroyed by the Member's misuse, abuse or carelessness; or if lost or stolen
132. Reproductive Health Care Services prohibited by the laws of This State
133. Requests for a referral
134. Research costs related to conducting the Approved Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials; Sanford Health Plan does not cover these costs.
135. Rest cures
136. Restorative replacements including crowns, bridges, braces or implants
137. Reversal of voluntary sterilization
138. Reversals of prior sterilization procedures; and
139. Revision of durable medical equipment, except when made necessary by normal wear or use
140. Revision/replacement of prosthetics (except as noted per Plan policy)
141. Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates
142. Self-help and adaptive aids are not a covered benefit, including assistive communication devices and training aids.
143. Sensitivity training

144. Sequela, which are primarily cosmetic that occur secondary to a weight loss procedure (e.g., Panniculectomy, breast reduction or reconstruction)
145. Service call charges, labor charges, charges for repair estimates
146. Services and supplies related to ridge augmentation, implantology, and preventive vestibuloplasty
147. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home that are not Medically Necessary
148. Services determined to be cosmetic by the Plan
149. Services for excluded benefits
150. Services for which the Member has no legal obligation to pay or for which no charge would be made if the Member did not have health plan or insurance coverage.
151. Services not medically appropriate or necessary
152. Services not performed in the most cost-efficient setting appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate
153. Services provided in the Member's home for convenience
154. Services related to environmental change
155. Services that are not Health Care Services
156. Services that are the responsibility of a Third Party Payor or are not billable to health insurance
157. Services that can be provided safely and effectively by a non-clinically trained person
158. Services that involve payment of family members or nonprofessional care givers for services performed for the member
159. Services to assist in activities of daily living
160. Services, chemotherapy, radiation therapy (or any therapy that damaged the bone marrow), supplies drugs and aftercare for or related to artificial or non-human organ transplants
161. Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by the Plan's Chief Medical Officer or its designee
162. Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating Center of Excellence
163. Shortening of the mandible or maxillae for cosmetic purposes
164. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered
165. Sports physicals, pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses)
166. Storage of stem cells including storing umbilical cord blood of non-diseased persons for possible future use
167. Sublingual allergy desensitization
168. Subsequent surgeries when no tangible evidence of Medical Necessity or improved quality of life exists.
169. Surgical procedures that can be done in a Practitioner office setting (i.e. vasectomy, toe nail removal)
170. Take-home drugs
171. Telecommunication Devices
172. Telephone assessment and management services
173. Therabands, cervical pillows, traction services,
174. Therapy and service animals, including those used for emotional or anxiety support
175. Tinnitus Maskers
176. Transfers performed only for the convenience of the Member, the Member's family, or the Member's Practitioner and/or Provider
177. Transmission fees
178. Transplant evaluations with no end organ complications

179. Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria
180. Transportation costs for non-emergency services and/or travel
181. Treatment of gradual deterioration of hearing that occurs with aging and/or other lifestyle factors, and related adult hearing screening services, testing and supplies
182. Treatment of infertility including artificial means of conception such as: artificial insemination, in-vitro fertilization, ovum or embryo placement or transfer, or gamete intra-fallopian tube transfer
183. Treatment received outside of the United States
184. Unspecified complication of kidney transplant
185. Upgrades of equipment for outdoor use, or equipment needed for use outside of the home that is not needed for in-home use, are not covered.
186. Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier
187. Virtual colonoscopies
188. Vitamins and minerals (unless otherwise specified as covered in this Policy)
189. Voluntary or involuntary drug testing unless a part of a Plan approved treatment plan
190. Wearable artificial kidney, each
191. Weight loss or exercise programs that do not meet the Plan's Medical Necessity coverage guidelines

4.2 GENERL PHARMACY EXLCUSIONS

1. Any medication equivalent to an OTC medication except for drugs 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
2. Compound medications containing any combination of the following: Baclofen, Bromfenac, Bupivicaine, Cyclobenzaprine, Gabapentin, Ketamine, Ketoprofen or Orphenadrine
3. Compound medications with no legend (prescription) medication
4. Drug Efficacy Study Implementation ("DESI") drugs
5. Experimental or Investigational medications or medication usage pursuant to the Plan's medical coverage policies
6. Food supplements and baby formula (except to treat phenylketonuria (PKU) or otherwise required to sustain life), nutritional and electrolyte substances
7. Lifestyle medications used to treat sexual dysfunction, impotence, or sexual inadequacy or to enhance sexual pleasure, intimacy or relationship enhancement
8. Medical Cannabis and/or its equivalents
9. Medication used to treat infertility
10. Medications and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless Provider certifies off-label use with a letter of Medical Necessity)
11. Medications for cosmetic purposes, including baldness, removal of facial hair, or pigmenting or anti-pigmenting of the skin
12. Medications not listed in the Plans Formulary
13. Medications obtained at a Non-Participating and/or Out-of-Network Pharmacy;
14. Medications that are obtained without Prior Authorization or a Formulary exception from the Plan
15. Medications that may be received without charge under a government program, unless coverage is required for the medication
16. Medications that provide little or no evidence of therapeutic advantage over other products available

17. Medications that require professional administration (may include: intravenous (IV) infusion or injection, intramuscular (IM) injections, intravitreal (ocular) injection, intra-articular (joint) injection, intrathecal (spinal) injections) will apply to the Member's medical benefit;
18. Orthomolecular therapy, including nutrients or vitamins unless otherwise specified as covered in this document
19. Over-the-counter (OTC) medications vitamins and/or supplements, equipment or supplies (except for insulin and select diabetic supplies, e.g., insulin syringes, needles, test strips and lancets) that by Federal or State law do not require a prescription order
20. Refills of any prescription older than one (1) year
21. Repackaged medications
22. Replacement of a prescription medication due to loss, damage, or theft
23. Self-administered medications dispensed in a Provider's office or non-retail pharmacy location
24. Unit dose packaging
25. Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia

4.3 SPECIAL SITUATIONS AFFECTING COVERAGE

Neither Sanford Health, nor any Participating Provider, shall have any liability or obligation because of a delay or a Participating Provider's inability to provide services as a result of the following circumstances:

- Complete or partial destruction of the Provider's facilities;
- Declared or undeclared acts of War or Terrorism;
- Riot;
- Civil insurrection;
- Major disaster;
- Disability of a significant portion of the Participating Providers;
- Epidemic; or
- A labor dispute not involving Participating Providers, we will use our best efforts to arrange for the provision of Covered Services within the limitations of available facilities and personnel. If provision or approval of Covered Services is delayed due to a labor dispute involving Participating Providers, Non-Emergency Care may be deferred until after resolution of the labor dispute.

Additionally, non-Emergency care may be deferred until after resolution of the above circumstances.

4.4 SERVICES COVERED BY OTHER PAYORS

The following are excluded from coverage:

- Health Care Services for which other coverage is either (1) required by federal, state or local law to be purchased or provided through other arrangements or (2) has been made available to and was purchased by the Covered Person. Examples include coverage required by Worker's compensation, no-fault auto insurance, medical payments coverage or similar legislation.
- The Certificate of Coverage is not issued in lieu of nor does it affect any requirements for coverage by Worker's Compensation. This Certificate of Coverage contains a limitation, which states that health services for injuries or sickness, which are job, employment or work, related for which benefits are paid under any Worker's Compensation or Occupational Disease Act or Law, are excluded from coverage under this Certificate of Coverage. However, if benefits are paid under the Certificate of Coverage, and it is determined that Member is eligible to receive Worker's Compensation for the same incident; Sanford Health Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Member will consent to reimburse Sanford Health Plan the full amount of the

Reasonable Costs when entering into any settlement and compromise agreement, or at any Worker's Compensation Division Hearing. Sanford Health Plan reserves its right to recover against Member even though:

- The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise; or
- No final determination is made that the injury or sickness was sustained in the course of or resulted from employment;
- The amount of Worker's Compensation for medical or health care is not agreed upon or defined by Member or the Worker's Compensation carrier; or
- The medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.

- Member will not enter into a compromise or hold harmless agreement relating to any work related claims paid under the Certificate of Coverage, whether or not such claims are disputed by the Worker's Compensation insurer, without the express written agreement of Sanford Health Plan.
- Health Care Services received directly from Providers employed by or directly under contract with the Member's employer, mutual benefit association, labor union, trust, or any similar person or Group.
- Health Care Services for conditions that under the laws of This State must be provided in a governmental institution.

4.5 SERVICES AND PAYMENTS THAT ARE THE RESPONSIBILITY OF MEMBER

- Out-of-pocket costs, including Copays, Deductibles, and Coinsurance are the responsibility of the Member in accordance with the attached Summary of Benefits and Coverage and Summary of Pharmacy Benefits. Additionally, the Member is responsible to a Provider for payment for Non-Covered Services;
- Finance charges, late fees, charges for missed appointments and other administrative charges; and
- Services for which a Member is neither legally, nor as customary practice, is required to pay in the absence of a group health plan or other coverage arrangement.

SECTION 5
HOW SERVICES ARE PAID FOR UNDER THE CERTIFICATE OF COVERAGE

5.1 REIMBURSEMENT OF CHARGES BY PARTICIPATING PROVIDERS

- When you see In-Network Participating Practitioner and/or Providers, receive services at In-Network Participating Practitioner and/or Provider Providers and facilities, or obtain your prescription drugs at In-Network Pharmacies, you will not have to file claims. You must present your current identification card and pay your Copay.
- When a Member receives Covered Services from an In-Network Participating Practitioner and/or Provider, Sanford Health Plan will pay the In-Network Participating Practitioner and/or Provider directly, and the Member will not have to submit claims for payment. The Member's only payment responsibility, in this case, is to pay the In-Network Participating Practitioner and/or Provider, at the time of service, any Copay, Deductible, or Coinsurance amount that is required for that service. In-Network Participating Practitioner and/or Providers agree to accept either Sanford Health Plan's payment arrangements or the negotiated contract amounts.

Time Limits. In-Network Participating Practitioner and/or Providers must file claims to Sanford Health Plan within one hundred eighty (180) days after the date that the cost was incurred. If the Member fails to show his/her ID card at the time of service, then the Member may be responsible for payment of claim after Practitioner and/or Provider's timely filing period of one hundred eighty (180) days has expired.

In any event, the claim must be submitted to Sanford Health Plan no later than one hundred eighty (180) days after the date that the cost was incurred, unless the claimant was legally incapacitated.

5.2 REIMBURSEMENT OF CHARGES BY NON-PARTICIPATING PROVIDERS

Sanford Health Plan does not have contractual relationships with Non-Participating Providers and they may not accept the Sanford Health Plan's payment arrangements. In addition to any Copay, Deductible, or Coinsurance amount that is required for that service, Members are responsible for any difference between the amount charges and Sanford Health Plan's payment for Covered Services. Non-Participating Providers are reimbursed the Maximum Allowed Amount, which is the lesser of:

- the amount charged for a Covered Service or supply; or
- inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or
- outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable:
    - Fees typically reimbursed to providers for same or similar professionals; or
    - Costs for facilities providing the same or similar services, plus a margin factor.

You may need to file a claim when you receive services from Non-Participating Providers. Sometimes these Practitioners and/or Providers submit a claim to us directly. Check with the Practitioner and/or Provider to make sure they are submitting the claim. You are responsible for making sure claim is submitted to Sanford Health Plan within one-hundred-eighty (180) days after the date that the cost was incurred.

If you, or the Non-Participating Provider, does not file the claim within 180 days after the date that the cost was incurred you will be responsible for payment of the claim.

If you need to file the claim, here is the process:

The Member must give Sanford Health Plan written notice of the costs to be reimbursed. Claim forms are available from the Customer Service Department to aid in this process. Bills and receipts should be itemized and show:

- Covered Member's name and ID number;
- Name and address of the Physician or Facility that provided the service or supply;
- Dates Member received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Time Limits: Claims must be submitted to Sanford Health Plan within one hundred eighty (180) days after the date that the cost was incurred. If you, or the Non-Participating Provider, file the claim after the one-hundred-eighty (180) timely filing limit has expired, you will be responsible for payment of the claim.

Submit your claims to: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110

5.3 BALANCE BILLING FROM NON-PARTICIPATING PROVIDERS

Balance billing, sometimes referred to as surprised billing, is the practice of a medical provider charging a patient for the difference between the total cost of services being billed and the amount the insurance pays. When a Member receives Covered Services from an In-Network Participating Practitioner and/or Provider, the Member is protected from balance billing because the provider cannot attempt to collect charges above what we have reimbursed. When Sanford Health Plan does not have a contractual relationship in place and the provider is a Non-Participating Provider, they may not accept Sanford Health Plan's payment arrangements and members may be balanced billed for services received.

Members may be balance billed in emergency situations even when Sanford Health Plan covers all of the charges at an In-Network Level if the provider is a Non-Participating Provider who will not accept our payment as full and final. Please check the Sanford Health Plan provider directory before receiving services to make sure you are seeing an In-Network Participating Practitioner and/or Provider.

5.4 HEALTH CARE SERVICES RECEIVED OUTSIDE OF THE UNITED STATES

Covered services for Medically Necessary emergency and urgent care services received in a foreign country are covered at the In-Network level. There is no coverage for elective Health Care Services if a Member travels to another country for the purpose of seeking medical treatment outside the United States.

5.5 TIMEFRAME FOR PAYMENT OF CLAIMS

- The payment for reimbursement of the Member's costs will be made within thirty *(30)* days of when Sanford Health Plan receives a complete written claim with all required supporting information.
- When a Member receives Covered Services from a Non-Participating Provider and payment is to be made according to our guidelines, Sanford Health Plan will arrange for direct payment to either the Non-Participating Provider or the Member. If the Provider refuses direct payment, the Member will be reimbursed for the Maximum Allowed Amount of the services in accordance with the terms of This Contract. The

Member will be responsible for any expenses that exceed Maximum Allowed Amount, as well as any Copay, Deductible, or Coinsurance required for the Covered Service.

5.6 WHEN WE NEED ADDITIONAL INFORMATION

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond

SECTION 6
COORDINATION OF BENEFITS

If a Member is covered by another health plan, insurance, or other coverage arrangement, the plans and/or insurance companies will share or allocate the costs of the Member's health care by a process called "Coordination of Benefits" so that the same care is not paid for twice.

The Member has two obligations concerning Coordination of Benefits ("COB"):

- The Member must tell Sanford Health Plan about any other plans or insurance that cover health care for the Member, and
- The Member must cooperate with Sanford Health Plan by providing any information requested by Sanford Health Plan.

The rest of the provisions under this section explain how COB works.

6.1 APPLICABILITY

This Coordination of Benefits (COB) provision applies to Sanford Health Plan when a Member has health care coverage under more than one Plan. "Plan" and "this Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another plan.

The benefits of this Plan:

- shall not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another plan; but
- may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in the section below entitled: *"Effect of COB on the Benefits of this Plan."*

6.2 DEFINITIONS (FOR COB PURPOSES ONLY)

"**Plan**" is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:

a) Group and non-group insurance contracts, health maintenance organization contracts, closed panel plans or other forms of Group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes medical benefits coverage in Group, Group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts.
b) "Plan" may include coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title MX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.), as amended from time to time).

Each contract or other arrangement for coverage under (a) or (b) is a separate plan. Also, if an arrangement has two (2) parts and COB rules apply only to one of the two, each of the parts is a separate plan.

"**This Plan**" refers to this certificate, which provides benefits for health care expenses.

"**Primary Plan/Secondary Plan**": The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another plan covering the Member and covered Dependents.

a) When this Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.
b) When this Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.
c) When there are more than two (2) plans covering the Member, this Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.

"**Allowable Expense**" means a necessary, reasonable and customary health care service or expense including Deductibles, Coinsurance, or Copays, that is covered in full or in part by one or more plans covering the person for whom the claim is made. If a plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Expenses that are not allowable include the following:

a) The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room (unless the Member's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined by the Plan) is not an allowable expense;
b) If a person is covered by two or more plans (excluding Medicare, see "Coordination of Benefits with Medicare" Section below) that compute the benefit payments on the basis of reasonable costs, any amount in excess of the highest of the reasonable costs for a specified benefit is not an allowable expense;
c) If a person is covered by two or more plans (excluding Medicare, see "Coordination of Benefits with Medicare" Section below) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense;
d) If a person is covered by one plan that calculates its benefits or services on the basis of reasonable costs and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be allowable expense for all plans; or
e) When benefits are reduced under a Primary Plan because a Member does not comply with The Plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, Certification of admissions or because the person has a lower benefit because the person did not use a preferred Practitioner and/or Provider.

"**Claim**" means a request that benefits of a plan be provided or paid in the form of services (including supplies), payment for all or portion of the expenses incurred, or an indemnification.

"**Claim Determination Period**" means a Calendar Year over which allowable expenses are compared with total benefits payable in the absence of COB to determine if over-insurance exists. However, it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or similar provision takes effect.

"**Closed Panel Plan**" is a plan that provides health benefits to Members primarily in the form of services through a panel of Practitioner and/or Providers that have contracted with or are employed by The Plan, and that limits or excludes benefits for services provided by other Practitioner and/or Providers, except in cases of emergency or Plan authorized referral by an In-Network Participating Practitioner and/or Provider.

"**Custodial Parent**" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

6.3 ORDER OF BENEFIT DETERMINATION RULES

General. When two or more plans pay benefits, the rules for determining the order of payment is as follows:

a) The primary plan pays or provides benefits as if the secondary plan or plans did not exist.
b) If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a non-panel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan;
c) If multiple contracts providing coordinated coverage are treated as a single plan under South Dakota State law, inclusive, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this law;
d) If a person is covered by more than one secondary plan, this order of benefit determination provisions decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of any primary plan and the benefits of any other plan, which has its benefits determined before those of that secondary plan;
e) Except as provided in subdivision (b) of this section, a plan that does not contain order of benefit determination provisions that are consistent with South Dakota State law, inclusive, is always the primary plan unless the provisions of both plans, regardless of the provisions of this section, state that the complying plan is primary;
f) Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

Rules. This Plan determines its order of benefits using the first of the following rules which applies:

Non-Dependent/Dependent. The plan which covers the person as a Group Member, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent. However, if the person is also a Medicare beneficiary, Medicare is:

- secondary to the Plan covering the person as a Dependent; and
- primary to the Plan covering the person as other than a Dependent, for example a retired Group Member; then the order of benefits between the two plans is reversed so that the plan covering the person as a Group Member, Member, or Subscriber is secondary and the other plan is primary.

Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:

- The primary plan is the plan of the parent whose birthday is earlier in the year if:
- The parents are married;
- The parents are not separated (whether or not they even have been married); or
- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that covered either of the parents longer is primary.

If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is

primary. This rule applies to claim determination periods or plan years commencing after The Plan is given notice of the court decree.

If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The plan of the custodial parent;
- The plan of the Spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the Spouse of the noncustodial parent.

Active/Inactive Group Member. The benefit of a plan, which covers a person as a Group Member who is neither laid off nor retired (or as that Group Member's Dependent), is primary. If the other plan does not have this rule, and if as a result the Plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a Dependent of an actively working Spouse will be determined under Rule 2(a) above.

Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to a federal or state law also is covered under another plan, the following shall be the order of benefit determination:

- primary, the benefits of a plan covering the person as a Group Member, Member or Subscriber (or as that person's Dependent);
- secondary, the benefits under the continuation coverage. If none of the above rules determines the order of benefits, the benefits of the plan that covered a Group Member, Member or Subscriber longer is primary.

If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

6.4 EFFECT OF COB ON THE BENEFITS OF THIS PLAN

When This Section Applies. This section applies when, in accordance with the "Order of Benefit Determination Rules," section above, this Plan is a Secondary Plan as to one or more other plans. In that event, the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in paragraph "b(ii)" immediately below.

Reduction in this Plan's Benefits. The benefits of this Plan will be reduced when the sum of:

- the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
- the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than 100% of those Allowable Expenses.

If a Member is enrolled in two or more closed panel plans and if, for any reason, including the provision of services by a Non-Participating Provider, benefits are not payable by one closed panel plan, COB shall not apply between this plan and any other closed panel plans.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

Plan's Right to Receive and Release Needed Information. Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. The Plan need not tell, or get the consent of any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to pay the claim.

Facility of Payment. A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this Plan. The Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:

- the persons it has paid or for whom it has paid;
- insurance companies; or
- other organizations.

The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

6.5 CALCULATION OF BENEFITS, SECONDARY PLAN

If Sanford Health Plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans for any claim or claims are not more than one hundred percent of total allowable expenses. In determining the amount of a claim to be paid by Sanford Health Plan, should The Plan wish to coordinate benefits, it shall calculate the benefits it would have paid in the absence of other insurance and apply that calculated amount to any allowable expense under The Plan that is unpaid by the primary plan. Sanford Health Plan may reduce its payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim.

6.6 COORDINATION OF BENEFITS WITH GOVERNMENT PLANS AND BENEFITS

After Sanford Health Plan, Medicare (if applicable), and/or any Medicare Supplementary Insurance (Medigap) have paid claims, then Medicaid and/or TRICARE pay last. Sanford Health Plan will pay primary to TRICARE and a State Child Health Insurance Plan (SCHIP) to the extent required by federal law.

IMPORTANT NOTICE TO PERSONS ON MEDICARE: THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is **NOT** a Medicare Supplement Insurance.

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance. This insurance duplicates Medicare benefits when it pays:

- the benefits stated in the policy and coverage for the same event is provided by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice
- [outpatient prescription drugs if you are enrolled in Medicare Part D]
- other approved items and services

6.7 COORDINATION OF BENEFITS WITH MEDICARE

The federal "Medicare Secondary Payer" (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account when:

- determining whether these individuals are eligible to participate in the Plan; or
- providing benefits under the Plan.

Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, Sanford Health Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether the person was enrolled under any of these parts. Sanford Health Plan reserves the right to coordinate benefits with respect to Medicare Part D. Sanford Health Plan will make this determination based on the information available through CMS.

When MSP Rules Apply to COB

Medicare Coordination of Benefits provisions apply when a Member has health coverage under this Certificate of Coverage and is eligible for insurance under Medicare, Parts A and B, (whether or not the Member has applied or is enrolled in Medicare). This provision applies before any other Coordination of Benefits Provision of this Certificate of Coverage.

Coordination with Medicare Part D

This Certificate of Coverage shall coordinate information relating to prescription drug coverage, the payment of premiums for the coverage, and the payment for supplemental prescription drug benefits for Part D eligible individuals enrolled in a Medicare Part D plan or any other prescription drug coverage.

The following provisions apply to Sanford Health Plan's COB with Medicare:

When Medicare is the primary payer for a Member's claims:

- If you're 65, or older, and have group health plan coverage based on your or your spouse's current employment
- If you have retiree insurance (insurance from former employment)

NOTE: The hospital or doctor will first file claims with Medicare. Once Medicare processes the claim, an Explanation Of Medicare Benefits (EOMB) form will be mailed to the Member explaining what charges were covered by Medicare. Then the health care professional will generally file the claim with us. If a professional does not do so, the Member may file the claim by sending a copy of the EOMB, together with his or her member identification number, to the address shown on his or her member ID card.

When Medicare is primary despite the MSP rules:

- A Medicare-entitled person refuses coverage under the Plan;*
- Medical services or supplies are covered by Medicare but are excluded under the group health plan;
- A Medicare-entitled person has exhausted his or her benefits under the group health plan;

- A person entitled to Medicare for any reason other than ESRD, experiences a COBRA qualifying event, and elects COBRA continuation;
- A person who was on COBRA becomes entitled to Medicare for a reason other than ESRD, and his or her COBRA coverage ends.

When this Certificate of Coverage is the primary payer for a Member's claims:

- If you're under 65 and disabled, and have coverage based on your or a family member's current employment
- When coverage is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA)
- The Member (actively-working Employee) is enrolled in Medicare because they are age 65 or older.
- A Covered Spouse, who is enrolled in Medicare because they are age 65 or older, regardless of the age of the Member/Employee.

NOTE: The Member's claim is filed with us by Practitioner or Provider. After the claim is processed, we send the Member an Explanation of Benefits (EOB) outlining the charges that were covered. We also notify the Practitioner or Provider of the covered charges. If there are remaining charges covered by Medicare, the Practitioner or Provider may file a claim with Medicare. If the Practitioner or Provider will not do so, the Member can file the claim with Medicare. Members may contact their local Social Security office to find out where and how to file claims with the appropriate "Medicare intermediary" (a private insurance company that processes Medicare claims).

If a Practitioner and/or Provider has accepted assignment of Medicare, Sanford Health Plan determines allowable expenses based upon the amount allowed by Medicare. Sanford Health Plan's allowable expense is the Medicare allowable amount. Sanford Health Plan pays the difference between what Medicare pays and Sanford Health Plan's allowable expense.

6.8 MEMBERS WITH END STAGE RENAL DISEASE (ESRD)

End-Stage Renal Disease (ESRD) is a medical condition in which a person's kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. Beneficiaries may become entitled to Medicare based on ESRD. Benefits covered by Medicare, because of ESRD, are for all Covered Services, not only those related to the kidney failure condition.

Sanford Health Plan does not differentiate in the benefits it provides to individuals who have ESRD, e.g. terminating coverage, imposing benefit limitations, or charging higher premiums.

How Primary vs. Secondary is Determined:

When coverage under this Certificate of Coverage is the primary payer for a Member's claims under ESRD:

- Sanford Health Plan will pay first for the first 30 months after you become eligible to join Medicare.
- During the Medicare coordination period of thirty (30) months, which begins with the earlier of:
    - The month in which a regular course of renal dialysis is initiated; or
    - In the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.
    - The Medicare COB period applies regardless of whether coverage is based on current employment status.

After the 30-month period, if a Member does not enroll in, or is no longer eligible for, Medicare.

When coverage is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA), or a retirement plan.

When Medicare is the primary payer for a Member's claims under ESRD:

- If the Member is eligible and enrolled in Medicare, Medicare will pay first after the coordination period for ESRD (30-months) has ended period.

6.9 COORDINATION OF BENEFITS WITH MEDICAID

- A Covered Individual's eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Individual. Any such benefit payments will be subject to the applicable State's right to reimbursement for benefits it has paid on behalf of the Covered Individual, as required by such state's Medicaid program; and Sanford Health Plan will honor any subrogation rights the State may have with respect to benefits that are payable under this Certificate of Coverage.
- When an individual covered by Medicaid also has coverage under this Certificate of Coverage, Medicaid is the payer of last resort. If also covered under Medicare, Sanford Health Plan pays primary, then Medicare, and Medicaid is tertiary.

See provisions below on Coordination of Benefits with TRICARE, if a Member is covered by both Medicaid and TRICARE.

6.10 COORDINATION OF BENEFITS WITH TRICARE

Generally, TRICARE is the secondary payer if the TRICARE beneficiary is enrolled in, or covered by, any other health plan to the extent that the service provided is also covered under the other plan.

- Sanford Health Plan pays first if an individual is covered by both TRICARE and Sanford Health Plan, as either the Member or Member's Dependent; and a particular treatment or procedure is covered under both benefit plans.
- TRICARE will pay last; TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim.
- When a TRICARE beneficiary is covered under Sanford Health Plan, and also entitled to either Medicare or Medicaid, Sanford Health Plan will be the primary payer, Medicare/Medicaid will be secondary, and TRICARE will be tertiary (last).
- TRICARE-eligible employees and beneficiaries receive primary coverage under this Certificate of Coverage in the same manner, and to the same extent, as similarly situated employees of the Plan Sponsor (Employer) who are not TRICARE eligible.

The Plan does not:

- Provide financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under the Plan, which would (in the case of such enrollment) be a primary plan (the incentive prohibition); and
- Deprive a TRICARE-eligible employee of the opportunity to elect to participate in this health benefit plan.

SECTION 7
SUBROGATION AND RIGHT OF REIMBURSEMENT

Sanford Health Plan will provide Health Care Services to the Member for the illness or injury, just as it would in any other case. However, if the Member accepts the services from Sanford Health Plan, this acceptance constitutes the Member's consent to the provisions discussed below.

Subrogation Defined

If a Member is injured or becomes ill because of an action or omission of a third party who is or may be liable to the Member for the injury or illness, Sanford Health Plan may be able to "step into the shoes" of the Member to recover health care costs from the party responsible for the injury or illness. This is called "Subrogation."

Reimbursement Defined

Sanford Health Plan has a right to reduce benefits, or to be reimbursed for that which it has provided to the Member. This is called "Reimbursement."

Covered Individuals

Each and every Covered Individual hereby authorizes Sanford Health Plan to give or obtain any medical or other personal information reasonably necessary to apply the provisions of Sections 6 and 7.

A Covered Individual will give this Plan the information it asks for about other plans and their payment of Allowable Charges. This Plan may give or obtain needed information from another insurer or any other organization or person.

7.1 SANFORD HEALTH PLAN'S RIGHTS OF SUBROGATION

In the event of any payments for benefits provided to a Member under this Plan, Sanford Health Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member, Member's parents, heirs, guardians, executors, or other representatives may have against any person or organization. These subrogation and reimbursement rights also include the right to recover from uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, automobile medical payments coverage, premises medical expense coverage, and Workers' Compensation insurance or substitute coverage.

Sanford Health Plan shall be entitled to receive from any such recovery an amount up to the Maximum Allowed Amount for the services provided by Sanford Health Plan. In providing benefits to a Member, Sanford Health Plan may obtain discounts from its health care Providers, compensate Providers on a capitated basis or enter into other arrangements under which it pays to another less than the reasonable costs of the benefits provided to the Member. Regardless of any such arrangement, when a Member receives a benefit under this Certificate of Coverage for an illness or injury, Sanford Health Plan is subrogated to the Member's right to recover the reasonable costs of the benefits it provides on account of such illness or injury, even if those reasonable costs exceed the amount paid by Sanford Health Plan.

Sanford Health Plan is granted a first priority right to subrogation or reimbursement from any source of recovery. Sanford Health Plan's first priority right applies whether or not the Member has been made whole by any recovery. Sanford Health Plan shall have a lien on all funds received by the Member, Member's parents, heirs, guardians, executors, or other representatives up to the Reasonable Costs Charge for any past, present, or future

Health Care Services provided to the Member. Sanford Health Plan may give notice of that lien to any party who may have contributed to the loss.

If Sanford Health Plan so decides, it may be subrogated to the Member's rights to the extent of the benefits provided or to be provided under this Plan. This includes Sanford Health Plan's right to bring suit against the third party in the Member's name.

7.2 SANFORD HEALTH PLAN'S RIGHT TO REDUCTION AND REIMBURSEMENT

Sanford Health Plan shall have the right to reduce or deny benefits otherwise payable by Sanford Health Plan, or to recover benefits previously paid by Sanford Health Plan, to the extent of any and all payments made to or for a Member by or on behalf of a third party who is or may be liable to the Member, regardless of whether such payments are designated as payment for, but not limited to, pain and suffering, loss of income, medical benefits or expenses, or other specified damages.

To the extent that federal or state statutes or courts, eliminate or restrict any such right of reduction or reimbursement provided to Sanford Health Plan under this Policy; such rights shall thus either be limited or no longer apply, or be limited by the extent of federal and state actions.

Sanford Health Plan shall have a lien on all funds received by the Member, Member's parents, heirs, guardians, executors, or other representatives up to the Maximum Allowed Amount for the Health Care Services provided to the Member.

7.3 ERRONEOUS PAYMENTS

To the extent payments made by Sanford Health Plan with respect to a Covered Individual are in excess of the Maximum Amount of payment necessary under the terms of this Certificate of Coverage, Sanford Health Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following sources, as this Plan shall determine any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which Sanford Health Plan determines are either responsible for payment or received payment in error, and any future benefits payable to the Covered Individual.

7.4 MEMBER'S RESPONSIBILITIES

The Member, Member's parents, heirs, guardians, executors, or other representatives must take such action, furnish such information and assistance, and execute such instruments as Sanford Health Plan requires to facilitate enforcement of its rights under this Certificate of Coverage. The Member shall take no action prejudicing the rights and interests of Sanford Health Plan under this provision.

Neither a Member nor Member's attorney or other representative is authorized to accept subrogation or reimbursement payments on behalf of Sanford Health Plan, to negotiate or compromise Sanford Health Plan's subrogation or reimbursement claim, or to release any right of recovery or reimbursement without Sanford Health Plan's express written consent.

Any Member who fails to cooperate in Sanford Health Plan's administration of this Part shall be responsible for the reasonable cost for services subject to this section and any legal costs incurred by Sanford Health Plan to enforce its rights under this section. Sanford Health Plan shall have no obligation whatsoever to pay medical benefits to a Covered Individual if a Covered Individual refuses to cooperate with Sanford Health Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as Sanford Health Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Covered Individual is a minor, Sanford Health Plan shall have no obligation to pay any medical benefits incurred on account of injury or illness

caused by a third-party until after the Covered Individual or his or her authorized legal representative obtains valid court recognition and approval of Sanford Health Plan's 100%, first-dollar Subrogation and refund rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Members must also report any recoveries from insurance companies or other persons or organizations arising form or relating to an act or omission that caused or contributed to an injury or illness to the Member paid for by Sanford Health Plan. Failure to comply will entitle Sanford Health Plan to withhold benefits, services, payments, or credits due under Sanford Health Plan.

7.5 SEPARATION OF FUNDS

Benefits paid by Sanford Health Plan, funds recovered by the Covered Individual(s), and funds held in trust over which Sanford Health Plan has an equitable lien exist separately from the property and estate of the Covered Individual(s), such that the death of the Covered Individual(s), or filing of bankruptcy by the Covered Individual(s), will not affect Sanford Health Plan's equitable lien, the funds over which Sanford Health Plan has a lien, or Sanford Health Plan's right to subrogation and reimbursement.

7.6 PAYMENT IN ERROR

If for any reason we make payment under this Policy in error, we may recover the amount we paid.

SECTION 8
HOW COVERAGE ENDS

8.1 TERMINATION BY THE SUBSCRIBER

Upon a qualifying event, you may be allowed to terminate coverage for you and/or any Dependent(s) at any time. Sanford Health Plan must receive a written request from the Group to end coverage. The Subscriber will be responsible for any Service Charges through the date of termination or the end of the calendar month in which termination occurs, whichever is later.

8.2 TERMINATION, NONRENEWAL, OR MODIFICATION OF MEMBER COVERAGE

A Member or Dependent's coverage will automatically terminate at the earliest of the following events below. Such action by Sanford Health Plan is called "Termination" of the Member.

1. **Failure to Pay Service Charge Payments**. Failure to make any required Service Charge payments when due. A grace period of thirty-one (31) days, following the due date will be allowed for the payment of any Service Charge after the first fee is paid. During this time, coverage will remain in force. If the Service Charge is not paid on or before the end of the grace period, coverage will terminate at the end of the grace period.
2. **Termination of Employment**. The last day of the month in which date the Member's active employment with the Group is terminated is the date benefits will cease for the Member(s).
3. **Termination of this Contract**. In the event this Contract terminates, the last day of the month for which Service Charge Payments were made is the date benefits will cease for the Member(s).
4. **Loss of Eligibility**. The last day of the month in which the Member is no longer an Eligible Group Member is the date benefits will cease for the Member(s).
5. **Movement Outside the Service Area**. The last day of the month in which the Member no longer resides in the Service Area is the date benefits will cease for the Member(s).
6. **Death.** The date the Member dies is the date benefits will cease for the Member(s).
7. **Fraudulent Information**. An act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, may be used to rescind this application or Certificate of Coverage, terminate coverage and deny claims. The date identified on the notice of termination is the date benefits will cease for the Member(s).
8. **Use of ID Card by Another.** The use of a Member's ID Card by someone other than the Member is considered fraud. The date a Member allows another individual to use his or her ID card to obtain services is the date benefits will cease for the Member(s).
9. **Product Discontinuance.** Sanford Health Plan discontinues a particular product provided that Sanford Health Plan provides the Group and all Group Members with written notice at least 90 days before the date the product will be discontinued, Sanford Health Plan offers the Group and all Group Members the option to purchase any other coverage currently being offered by Sanford Health Plan to group health plans, and Sanford Health Plan acts uniformly without regard to claims experience of the Group or any health status-related factor relating to particular Group Members covered or who may be eligible for coverage. The date identified in the notice of discontinuance is the date benefits will cease for the Member(s)

10. **Discontinuance of All Coverage in Group Market or All Markets.** Sanford Health Plan discontinues offering all coverage in the group market or in all markets in Minnesota provided that Sanford Health Plan provides the Group and all Group Members and the Minnesota Department of Insurance with written notice of the discontinuance at least 180 calendar days prior to the date the coverage will be discontinued and all coverage issued or delivered by Sanford Health Plan in the group market in Minnesota are discontinued and not renewed. The date identified in the notice of discontinuance is the date benefits will cease for the Member(s).
11. **Any other reason permitted by State or federal law**.

Notification

Sanford Health Plan must notify all covered persons of the termination at least 30 days before the effective termination date for the termination to be effective

Uniform Modification of Coverage

Sanford Health Plan may, at the time of renewal and with 60 days prior written notice, modify the Contract if the modification is consistent with State law and is effective uniformly for all persons who have coverage under this type of contract.

8.3 MEMBER APPEAL OF TERMINATION

A Member may Appeal Sanford Health Plan's decision to terminate, cancel, or refuse to renew the Member's coverage. The Appeal will be considered a Member Grievance and the Sanford Health Plan's Policy on Member Grievances and Appeals will govern the process.

Pending the Appeal decision, coverage will terminate on the date that was set by Sanford Health Plan. However, the Member may continue coverage, if entitled to do so, by complying with the "Continuation of Coverage" provisions in Section 9. If the Appeal is decided in favor of the Member, coverage will be reinstated, retroactive to the effective date of termination, as if there had been no lapse in coverage.

NOTE: A Member may not be terminated due to the status of the Member's health or because the Member has exercised his or her rights to file a complaint or appeal.

8.4 CONTINUATION OF COVERAGE FOR CONFINED MEMBERS

Any Member who is an inpatient in a Hospital or other Facility on the date of coverage termination under this Benefit Plan will be covered in accordance with the terms of this Certificate until they are discharged from such Hospital or other Facility. Applicable charges for coverage that was in effect prior to termination of this Certificate will apply.

8.5 EXTENSION OF BENEFITS FOR TOTAL DISABILITY

An extension of benefits is provided Covered Members/Subscribers who become totally disabled while enrolled under this Benefit Plan and whom continue to be totally disabled at the date of termination of this Certificate. Upon payment applicable premium charges at the current Group rate, coverage will remain in full force and effect until the first of the following occurs:

1. The end of a period of twelve (12) months starting with the date of termination of the Group contract;
2. The date the Member is no longer totally disabled; or
3. The date a succeeding plan provides replacement coverage to that Member without limitation as to the disabling condition.

Upon termination of the extension of benefits, the Member/Subscriber will have continuation and conversion rights as stated in Sections 9 and 10.

8.6 NOTICE OF GROUP TERMINATION OF COVERAGE

1. Termination due to Non-Renewal

The Group will give thirty (30) days written notice of the termination to the Members. For purposes of This Contract, "give written notice" means to present the notice to the Member or mail it to the Member's last known address.

This notice will set forth at least the following:

- The effective date and hour of termination or of the decision to not renew coverage;
- The reason(s) for the termination or nonrenewal; and
- The Member's options listed below, including requirements for qualification and how to exercise the Member's rights:
    - the availability of Continuation of Coverage, if any; and
    - the fact that the Member may have rights under federal COBRA provisions, independent from any provisions of This Contract, and should contact the Group for information on the COBRA provisions.

2. Termination due to Non-Payment of Premiums

If an employer fails to submit Premium payment to Sanford Health Plan resulting in loss of coverage to the Members, switches plans or cancels the coverage, The Group is required to give written notice of the termination to the Members as soon as reasonably possible but no later than ten (10) days after the date of termination.

SECTION 9
OPTIONS AFTER COVERAGE ENDS

9.1 FEDERAL CONTINUATION OF COVERAGE PROVISIONS ("COBRA")

Notice of Continuation Coverage Rights Under COBRA for employer groups with twenty (20) or more employees

Introduction

You are getting this notice because you recently gained coverage under an employer sponsored group health plan (the Plan). This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when employer sponsored group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review your Plan Document (Policy) or contact the Plan Administrator (your Employer).

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Health Insurance Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept "Late Entrants".

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary."

You, your Spouse, and your Dependent Children could become qualified beneficiaries if coverage is lost because of the qualifying event. Qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee and the Plan is subject to COBRA, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse and the Plan is subject to COBRA, you will become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;

- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

If the Plan is subject to COBRA, your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage as a "Dependent Child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the employer sponsoring coverage under the Plan, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a qualified beneficiary. The retired employee's spouse, surviving spouse, and Dependent Children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Coverage Available?

The employer is responsible for the timely mailing of applicable COBRA notices to Members (the "COBRA Notification Letter"). The employer must notify Sanford Health Plan when qualifying events occur. Sanford Health Plan will offer COBRA continuation coverage to qualified beneficiaries only after being notified by the employer that a qualifying event has occurred. The employer must notify the Plan of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For other qualifying events (such as divorce or legal separation of the employee and Spouse or a child losing eligibility for coverage as a Dependent Child), you may notify Sanford Health Plan at (800) 752-5863 (toll-free) | TTY/TDD (877) 652-1844 (toll-free).

How is COBRA Coverage Provided?

Upon notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses and Dependent Children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a qualified beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

- If you or a covered Dependent is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your covered Dependents may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage.
- Second qualifying event extension of 18-month period of continuation coverage
- If you or your covered Dependents experience another qualifying event during the 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if your employer is properly notified about the second qualifying event.
- This extension may be available to your Spouse and any Dependent Children getting COBRA continuation coverage if the employee or former employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent Child stops being eligible under the Plan as a Dependent Child. This extension is only available if the second qualifying event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

How is COBRA Coverage Elected?

- To elect continuation coverage, when Sanford Health Plan is administering your COBRA coverage, you must call Customer Service toll-free at (800) 752-5863 or TTY/TDD: (877) 652-1844 (toll-free) and complete the Plan's Election Form. The election period to request a continuation of coverage will expire sixty (60) days from the date of the Member's election notice.
- Each qualified beneficiary has a separate right to elect continuation coverage. For example, the Spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all Dependent Children who are qualified beneficiaries.
- In considering whether to elect continuation coverage, you should take in to account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within thirty (30) days after your group health coverage ends because of a qualifying event listed above under "What is COBRA Continuation Coverage." You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

If continuation coverage (COBRA) is not timely elected, your coverage will end.

When and how must payment be made for COBRA continuation coverage administered by Sanford Health Plan?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the COBRA Election Form.

However, you must make your first payment to Sanford Health Plan no later than forty-five (45) days after the date of your election. Your Election Date is the date the Election Notice is post-marked, if mailed.

If you do not make your first payment for continuation coverage in full no later than forty-five (45) days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact Sanford Health Plan's Customer Service Department to confirm the correct amount of your first payment.

Periodic payments for continuation of coverage

After you make your first payment for continuation coverage, you will be required to make periodic payment for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the COBRA Notification Letter. The periodic payments can be made on a monthly basis. Each of these periodic payments for continuation coverage is due on the first day of each month for that coverage period. If you make a periodic payment before the first day of each month, your coverage will continue for that coverage period without any break.

Grace Periods for periodic payments

Although periodic payments are due on the first day of each month, you will be given a grace period of thirty (30) days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which applies, but before the end of the grace period for the coverage period, your coverage will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claims you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

If Sanford Health Plan is administering your COBRA coverage: Your first COBRA premium payment, and all periodic payments should be sent to: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. Contact your employer to determine the COBRA administrator.

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan Member or beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in the COBRA Notification Letter.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

The Uniformed Services Employment and Reemployment Rights Act (USERRA)

The Uniformed Services Employment and Reemployment Rights Act (USERRA) requires employers to offer employees and their Spouse and/or Dependent Children the opportunity to pay for a temporary extension of health coverage (called continuation coverage) at group rates in certain instances where the employee leaves the position of employment due to service in the military. The Member or the Member's Authorized Representative may elect to continue the employee's coverage by making an election of a form provided by Sanford Health Plan. The Member has sixty (60) days to elect continuation coverage measured from the later of (1) the date the

employee left the position of employment, or (2) the date notice of election rights is received. If continuation coverage is elected within this period, the coverage will be retroactive to the date the employee left the position of employment.

The Member may elect continuation coverage on behalf of a covered Dependent; however, there is no independent right of each covered Dependent to elect continuation of coverage. If the Member does not elect coverage, there is no USERRA continuation available for the Spouse or Dependent Children. In addition, even if the Member does not elect USERRA coverage or continuation coverage, the Member has the right to have coverage reinstated upon reemployment. Continuation coverage continues for up to twenty-four (24) months.

This section is to inform covered individuals, in summary fashion, of their rights and obligations under the continuation of coverage provisions of USERRA. It is intended that no greater rights be provided than those required by federal law.

If You Have Questions

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available in your summary plan description, from the Plan Administrator or from your employer.

If you have any questions concerning the information in this notice, your rights to coverage, or if you want a copy of your summary plan description, you should contact your employer. Customer Service

For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Health Insurance Marketplace, visit www.healthcare.gov.

Keep Sanford Health Plan Informed of Address Changes

To protect your family's rights, let Sanford Health Plan know about any changes in the addresses of covered Dependents. You should also keep a copy, for your records, of any notices you send to Sanford Health Plan.

COBRA Contact Information

Mail:	Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.
Phone:	(800) 752-5863 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free)
	For free help in a language other than English: (800) 892-0675 (toll-free)
Fax:	(605) 328-6812
Online:	www.sanfordhealthplan.com/memberlogin

Or contact your employer.

9.2 STATE CONTINUATION OF COVERAGE PROVISIONS

Continuation of Coverage Provisions for Members not affected by COBRA

State law permits Members to continue coverage under an employer Group health plan under certain circumstances. That is, if the Group, as an employer, changes from Sanford Health Plan to another health plan or insurance carrier, the right to continuation under state law is a Subscriber right, which transfers to the new carrier or to claims adjudication under the new administrator.

In general, Subscribers and their covered Dependents who were continuously covered under the Plan during a six (6) month period immediately preceding termination of coverage, have a right to continue Group health coverage if they lose coverage because of termination of the Subscriber's employment. Continuation does not include dental, vision care or prescription drug benefits or any other benefits provided under the Group Certificate of Coverage in addition to its major medical benefits.

Subscribers and their Covered Dependents have a right to continue coverage for twelve (12) weeks from the date of termination. In the case of individuals who are disabled within the meaning of the Social Security Act, special rules may apply to extend coverage as provided by South Dakota Administrative Code. See the Extension of Benefits for Total Disability set forth in Section 8.

However, the right to continue Group coverage shall terminate upon the happening of the following events:

1. The Member becomes covered by Medicare.
2. The Member becomes covered by any other insured or uninsured arrangement which provides Hospital, surgical, or medical coverage for individuals in a group and under which the person was not covered immediately prior to the termination.
3. Or, if earlier, at the first to occur of the following:
4. The date twelve (12) weeks after the date the Member's insurance under the Certificate of Coverage would otherwise have terminated because of termination of employment or Membership.
5. If the Member fails to make timely payment of the required Service Charge payment, the end of the period for which the Service Charges were made.
6. The date on which the Group Certificate of Coverage is terminated or the date the employer terminates participation under the Group Certificate of Coverage. However, if this subdivision applies and the coverage ceasing by reason of such termination is replaced by similar coverage under another group Certificate of Coverage, the following apply:
7. The Member may become covered under that other group Certificate of Coverage for the balance of the period that the Member would have remained covered under the prior group Certificate of Coverage, had the termination not occurred; and
8. The minimum level of benefits to be provided by the replacement group Certificate of Coverage is the applicable level of benefits of the prior group Certificate of Coverage reduced by any benefits payable under that prior group Certificate of Coverage; and
9. The prior group Certificate of Coverage must continue to provide benefits to the extent of its accrued liabilities and extensions of benefits as if the replacement had not occurred.

Continuation Coverage for Former Spouses and Dependent Children

If because of entry of a decree of annulment from marriage or divorce, a Spouse or Dependent is no longer eligible for coverage under this Plan, the Spouse or Dependent may apply for continuation coverage until the earliest of:

a. Thirty-six (36) months after continuation of coverage began; or. The date the Subscriber's former spouse becomes remarried; orc. The date coverage would otherwise terminate under the Contract.

When continuation coverage under this section ends, Members have the option to enroll in an individual conversion plan a described in the Conversion of Coverage section below.

Election Rights

When the employer is notified that one of the above events has occurred, the Plan or Sanford Health Plan will send the Subscriber or Dependent who qualifies for continuation of coverage a notice of the right to continue coverage. The Subscriber or Dependent has ten (10) days to elect continuation coverage, in writing, measured from the later of:

a. The date of termination of employment.
b. The date notice of election rights is received by the Member.

A period of thirty-one (31) days after the date of termination is allowed in which the Member has to elect continuation of coverage. If Sanford Health Plan receives the written election for continuation coverage within this period, the coverage will be retroactive to the date coverage would have otherwise been lost.

Payment of Service Charges

Upon receipt of the continuation of coverage election form, the Plan or Sanford Health Plan will send the Subscriber or Dependent who qualifies for continuation of coverage a notice of the amount of dues needed for the continued benefits. A period of thirty-one (31) days is allowed in which to pay the initial required Service Charge payment. The first Service Charge payment will be for a period commencing with the date following the date coverage would otherwise terminate. The Service Charges will be the same as those for actively employed Subscribers unless coverage under the Contract has been lost because of entry of a decree of annulment from marriage or divorce, in which case the amount charged will be 102% of the cost of coverage for actively employed Subscribers. Subsequent Service Charge payments will be allowed a thirty-one (31) day grace period after the due date. Sanford Health Plan or the Plan will bill the Member directly and payment will be made according to the invoice instructions.

Enrollment and Benefit Changes

a. If the Group changes benefits, the Subscriber's benefits will also change to match the Group's new benefit package.
b. The Subscriber has the same right to change benefit programs as the active Group Members. A Pre-Existing Condition waiting period may not be applied to a transferring Subscriber and his or her covered Dependents.
c. If the Group changes plans or insurers during the period of Continued Group Benefits, the Subscribers for the Group will be canceled as to coverage under this Contract and become the responsibility of the new health plan or insurer.

Conversion of Coverage Provisions

Except as stated in paragraph (b), a Member who has been continuously covered under the Group Contract for at least three (3) months is entitled to a conversion contract if the Member is no longer eligible for coverage under the Group Contract or the Group Contract terminates. A Member is not entitled to a conversion contract in the following circumstances.

a. The Member's loss of eligibility under the Group Contract was based upon the Member's failure to pay amounts due under the Group Contract, the Member engaged in fraud or a material misrepresentation in enrollment or in the use of services or facilities, or the Member materially violated the terms of the Group Contract,
b. The Member is covered by or is eligible for benefits under Medicare.
c. The Member is covered by or is eligible for similar hospital, medical or surgical benefits under state or federal law.
d. The Member is covered by or is eligible for similar hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group.
e. The Member is covered for similar benefits by an individual policy or contract.

To obtain the conversion contract the Member must submit a written application and any applicable premium to Sanford Health Plan within thirty-one (31) days after the Member's loss of eligibility or the date the Group Contract terminates. The Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period.

9.3 Renewal & Reinstatement

1. **Renewal**. The Group Contract shall automatically renew for additional one (1) year periods unless either the Group or Plan gives the other written notice of its intention not to renew at least thirty (30) days prior to the Group Contract's expiration date. The Group's Contract Service Charge addendum will be reissued on an annual basis and will be in effect for the term specified therein.
2. **Reinstatement**. If the Group fails to pay a Service Charge when due and this Contract is terminated by Sanford Health Plan, in addition to any other rights and remedies available to Sanford Health Plan under the Group Contract or in law or equity, the Plan reserves the right to reinstate the Group. In the event the Group Contract is terminated and the Group desires reinstatement of coverage, the Group shall send written notice to the Plan. Sanford Health Plan shall have sole and absolute discretion in determining whether to reinstate the Group. In the event Sanford Health Plan reinstates coverage for the Group, the Group shall submit to Sanford Health Plan any reinstatement fees due in an amount determined by the Group's Contract with Sanford Health Plan, prior to coverage being reinstated.

SECTION 10
PROBLEM RESOLUTION

10.1 MEMBER APPEAL PROCEDURES - OVERVIEW

Sanford Health Plan makes decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Benefits under this Certificate of Coverage will be paid only if Sanford Health Plan decides, at Sanford Health Plan's discretion, that the applicant is entitled to them.

Claims for benefits under this Certificate of Coverage can be post-service, pre-service, or concurrent. This Section of your Summary Plan Description explains how you can file a complaint regarding services provided by Sanford Health Plan; or appeal a partial or complete denial of a claim. The appeal procedures outlined below are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

For information on medication/drug Formulary exception requests, see Section 4, *Pharmaceutical Review Requests and Exception to the Formulary Process*.

The following parties may request a review of any Adverse Determination by Sanford Health Plan: the Member and/or legal guardian; a health care Practitioner and/or Provider with knowledge of the Member's medical condition; an Authorized Representative of the Member; and/or an attorney representing the Member or the Member's estate.

NOTE: The Member or his/her legal guardian may designate in writing to Sanford Health Plan an Authorized Representative to act on his/her behalf. In cases where the Member wishes to exercise this right, a written designation of representation from the Member should accompany a Member's complaint or request to Appeal an Adverse Determination. See *Designating an Authorized Representative* below for further details. For urgent (expedited) appeals, written designation of an Authorized Representative is not required.

Special Communication and Language Access Services

For Members who request language services, Sanford Health Plan will provide services at no charge in the requested language through an interpreter. Translated documents are also available at no charge to help Members submit a complaint or appeal, and Sanford Health Plan will communicate with Members free of charge about their complaint or appeal in the Member's preferred language, upon request. To get help in a language other than English, call (800) 892-0625.

For Members who are deaf, hard of hearing, or speech-impaired

To contact Sanford Health Plan, a TTY/TDD line is available free of charge by calling toll-free (877) 652-1844.

Help to understand this policy and your rights is free.
If you would like it in a different format (for example, in a larger font size),
please call us at (800) 752-5863 (toll-free).
If you are deaf, hard of hearing, or speech-impaired,
reach us at TTY/TDD: (877) 652-1844 (toll-free).

Help in a language other than English is also free.
Please call (800) 892-0675 (toll-free) to connect with us using free translation services.

Maximum Appeal Timelines			
Type of Notice	**Emergency**	**Pre-Service**	**Post-Service**
Initial Determinations	24 Hours	15 days	30 Days
Extension for Initial Plan Determinations	NONE	15 days	15 Days
Additional Information Request (Plan)	24 Hours	15 days	15 Days
Response to Request For Additional Information (Member)	48 Hours	45 Days	45 Days
Request for Internal Appeal (Member)	180 Days	180 Days	180 Days
Internal Appeal Determinations	240 Hours	30 Days	60 Days
Request for External Appeal (Member)	N/A	4 months	4 Months
External Appeal Determinations	72 Hours	45 Days	45 Days

10.2 DESIGNATING AN AUTHORIZED REPRESENTATIVE

You must act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. If you wish to designate an Authorized Representative, you must do so in writing. You can get a form by calling Customer Service toll-free at (800) 752-5863; or logging into your account at www.sanfordhealthplan.com/memberlogin. If a person is not properly designated in writing as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Policy.

For urgent pre-service claims, we will presume that your provider is your Authorized Representative unless you tell us otherwise, in writing.

10.3 AUDIT TRAILS

Audit trails for Complaints, Adverse Determinations and Appeals are provided by Sanford Health Plan's Information System and an Access database which includes documentation of the Complaints, Adverse Determination and/or Appeals by date, service, procedure, substance of the Complaint/Appeal (including any clinical aspects/details, and reason for the Complaint, Adverse Determination and/or Appeal.
The Appeal file includes telephone notification, and documentation indicating the date; the name of the person spoken to; the Member; the service, procedure, or admission certified; and the date of the service, procedure, or Adverse Determination and reason for determination. If Sanford Health Plan indicates authorization (Certification) by use of a number, the number will be called the "authorization number."

10.4 DEFINITIONS

Adverse Determination: A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment (for pre-service or post-service claims) based on:

1. A determination of an individual's eligibility to participate in a plan;
2. A determination that a benefit is not a Covered Benefit;

3. The imposition of a source-of-injury exclusion, network exclusion, application of any Utilization Review, or other limitation on otherwise covered benefits;
4. A determination that a benefit is Experimental, Investigational or not Medically Necessary or appropriate; or
5. A rescission of coverage. Only an act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, made by an applicant for health insurance coverage may be used to void application or policy and deny claims.

Appeal: A request to change a previous Adverse Determination made by Sanford Health Plan.

Inquiry: A telephone call regarding eligibility, plan interpretation, plan policies and procedures, or plan design. It is the policy of Sanford Health Plan to address Member and Practitioner and/or Provider inquiries through informal resolution over the telephone whenever possible. If the resolution is not satisfactory to the inquirer, he or she will be instructed of his or her rights to file a verbal or written Complaint.

Complaint: An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and Practitioner and/or Provider Complaints. A process has been established for Members (or their designees) and Practitioners and/or Providers to use when they are dissatisfied with Sanford Health Plan, its Practitioners and/or Providers, or processes. Examples of Complaints are eligibility issues; coverage denials, cancellations, or non-renewals of coverage; administrative operations; discrimination based on race, color, national origin, sex, age, or disability; and the quality, timeliness, and appropriateness of health care services provided.

Complainant: This is a Member, applicant, or former Member or anyone acting on behalf of a Member, applicant, or former Member, who submits a Complaint. The Member and his/her legal guardian may designate in writing to Sanford Health Plan an Authorized Representative to act on his/her behalf. This written designation of representation from the Member should accompany the Complaint.

External Review: An External Review is a request for an Independent, External Review of a medical necessity final determination made by Sanford Health Plan through its External Appeals process.

Urgent Care Situation: A degree of illness or injury that is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours. An Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination could:

a. Seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgment; or
b. In the opinion of a Practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

In determining whether a request is "Urgent," Sanford Health Plan shall apply the judgment of a Prudent Layperson as defined in Section 8. A Practitioner, with knowledge of the Member's medical condition, who determines a request to be "Urgent," as defined in Section 8, shall have such a request treated as an Urgent Care Request by Sanford Health Plan.

10.5 COMPLAINT (GRIEVANCE) PROCEDURES

A Member has the right to file a Complaint either by telephone or in writing to The Appeals and Complaints Department. The Appeals and Complaints Department will make every effort to investigate and resolve all Complaints. The Appeals and Complaints Department can be reached at (877) 652-8544.

10.6 ORAL COMPLAINTS

A complainant may orally submit a Complaint to Customer Service. If the oral Complaint is not resolved to the complainant's satisfaction within ten (10) business days of receipt of the Complaint, Sanford Health Plan will provide a Complaint form to the complainant, which must be completed and returned to the Appeals and Complaints Department for further consideration. Upon request, Customer Service will provide assistance in submitting the Complaint form.

10.7 WRITTEN COMPLAINTS

A complainant can seek further review of a Complaint not resolved by phone by submitting a written Complaint form. A Member, or his/her Authorized Representative may send the completed Complaint form, including comments, documents, records and other information relating to the Complaint, the reasons they believe they are entitled to benefits and any other supporting documents to:

Sanford Health Plan
Appeals and Complaints Department
PO Box 91110
Sioux Falls, SD 57109-1110

Complaints based on discrimination must be sent to the attention of the Civil Rights Coordinator.

The Appeals and Complaints Department will notify the complainant within *ten* (10) business days upon receipt of the Complaint form, unless the Complaint has been resolved to the complainant's satisfaction within those ***ten* (10) business days**.

Upon request and at no charge, the complainant will be given reasonable access to and copies of all documents, records and other information relevant to the Complaint.

10.8 COMPLAINT INVESTIGATIONS

The Appeals and Complaints Department will investigate and review the Complaint and notify the complainant of Sanford Health Plan's decision in accordance with the following timelines:

- A decision and written notification on the Complaint will be made to the complainant, his or her Practitioners and/or Providers involved in the provision of the service within *thirty* (30) calendar days from the date Sanford Health Plan receives your request.
- In certain circumstances, the time period may be extended by up to *fourteen* (14) days upon agreement. In such cases, Sanford Health Plan will notify the complainant in advance, of the reasons for the extension.

Any complaints related to the quality of care received are subject to practitioner review. If the complaint is related to an urgent clinical matter, it will be handled in an expedited manner, and a response will be provided within *twenty-four* (24) hours.

If the complaint is not resolved to the Member's satisfaction, the Member, or his/her Authorized Representative, has the right to Appeal any Adverse Determination made by Sanford Health Plan. Appeal Rights may be requested by calling the Appeals and Complaints Department at (877) 652-8544.

Sanford Health Plan will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in the complaint or appeals process.

All notifications described above will comply with applicable law. A complete description of your Appeal rights and the Appeal process will be included in your written response.

10.9 APPEAL PROCEDURES

Types of Appeals
Types of appeals include:

- **A Pre-service Appeal** is a request to change an Adverse Determination that Sanford Health Plan approved in whole or in part in advance of the Member obtaining care or services.
- **A Post-service Appeal** is a request to change an Adverse Determination for care or services already received by the Member.
- An **Expedited Appeal** for Urgent Care is a request to change a previous Adverse Determination made by Sanford Health Plan for an Urgent Care Request. If the Member's situation meets the definition of urgent, their review will generally be conducted within 24 hours.

10.11 CONTINUED COVERAGE FOR CONCURRENT CARE

A Member is entitled to continued coverage for concurrent care pending the outcome of the appeals process; benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow the claimant to Appeal and obtain a review determination before the benefit is reduced or terminated. Review determinations would be made within twenty-four (24) hours.

10.12 INTERNAL APPEALS OF ADVERSE DETERMINATION (DENIAL)

Appeals can be made for up to 180 days from notification of the Adverse Determination.

Within one-hundred-eighty (180) days after the date of receipt of a notice of an Adverse Determination sent to a Member or the Member's Authorized Representative (as designated in writing by the Member), the Member or their Authorized Representative may file an Appeal with Sanford Health Plan requesting a review of the Adverse Determination. An Appeal Filing Form may be found on the Member's online account at www.sanfordhealthplan.com/memberlogin.

The Member or the Authorized Representative should contact Sanford Health Plan by calling or sending a written Appeal (using the Appeal Filing Form is optional) to the following address: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. Phone: (800) 752-5863 | TTY/TDD: (877) 652-1844 (toll-free). Sanford Health Plan also accepts appeals via fax at (605) 312-8910.

10.13 APPEAL RIGHTS AND PROCEDURES

If the Member or their Authorized Representative (as designated in writing by the Member) files an Appeal for an Adverse Determination, the following Appeal Rights apply:

- The Member shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. Members do not have the right to attend or have a representative attend the review.
- The Member shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by, or at the direction of, Sanford Health Plan in connection with the claim; and such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is required to be provided to give the Member a reasonable opportunity to respond prior to that date.
- Confirm with the Member whether additional information will be provided for appeal review. Sanford Health Plan will document if additional information is provided or no new information is provided for appeal review.
- Before Sanford Health Plan can issue a final Adverse Determination based on a new or additional rationale, the Member will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Determination is required to be provided and give the Member a reasonable opportunity to respond prior to the date. Members shall have the right to review all evidence and present evidence and testimony.
- The Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Member's initial request.
- The review shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- Full and thorough investigation of the substance of the Appeal, including any aspects of clinical care involved, will be coordinated by the Appeals and Complaints Department.
- Sanford Health Plan will document the substance of the Appeal, including but not limited to, the Member's reason for appealing the previous decision and additional clinical or other information provided with the appeal request. Sanford Health Plan will also document any actions taken, including but not limited to, previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal.
- The review shall not afford deference to the initial Adverse Determination and shall be conducted by a Sanford Health Plan representative who is neither the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of any Adverse Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational, or not Medically Necessary or appropriate, Sanford Health Plan shall consult with a health care professional (same-or-similar specialist) who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care Practitioner and/or Provider engaged for purposes of a consultation under this paragraph shall be an individual who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Sanford Health Plan shall identify the medical or vocational experts whose advice was obtained on behalf of Sanford Health Plan in connection with a Member's Adverse Determination, without regard to whether the advice was relied upon in making the benefit request determination.
- In order to ensure the independence and impartiality of the persons involved in making claims determinations and appeals decisions, all decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

- The attending Practitioner and/or Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Appeal within three (3) working days of receipt of the Appeal.
- Sanford Health Plan will provide notice of any Adverse Determination in a manner consistent with applicable federal regulations.

10.15 APPEAL NOTIFICATION TIMELINES

For Prospective (Pre-service) Appeals: for decisions not regarding pharmacy service, certification of non-covered medication, or Formulary design issues, Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within **thirty (30) calendar days** of receipt of the Appeal.

For Retrospective (Post-service) Appeals: for decisions not regarding pharmacy service, certification of non-covered medication, or Formulary design issues, Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within **sixty (60) calendar days** of receipt of the Appeal.

For Appeals Based on Discrimination: Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing within **thirty (30) calendar days** of receipt of the Appeal.

If the Member does not receive the decision within the time periods stated above, the Member may be entitled to file a request for External Review.

10.16 EXPEDITED INTERNAL APPEAL PROCEDURE

An Expedited Appeal procedure is used when the Member's condition is emergent or urgent in nature, as defined in this Certificate. An Expedited Appeal of a Prior Authorization (Pre-service) Denial must be utilized if the Practitioner acting on behalf of the Member believes that the request is warranted. This can be done by oral or written notification to Sanford Health Plan. We will accept all necessary information (electronic or by telephone) for review from the Practitioner of care. A designated Physician advisor will conduct the review and will be available to discuss the case with the attending Practitioner on request. For Medical Necessity reviews only, a Practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the request.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the Appeal via telephone by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than within *seventy-two (72) hours* of receipt of the request. The Member and those Practitioners and/or Providers involved in the Appeal will receive written notification within *three (3) calendar days* of the telephone notification.

If the Expedited Review is a Concurrent Review determination, the service will be continued without liability to the Member until the Member or the Representative has been notified of the determination.

NOTE: For procedures, rights, and notification timelines related to an Appeal of Adverse Determination regarding pharmacy services, certification of a non-covered medication, or Formulary design issues, see External Procedures for Adverse Determinations of Pharmaceutical Exception Requests in this Section.

10.17 WRITTEN NOTIFICATION PROCESS FOR INTERNAL APPEALS

The written decision for the Appeal reviews will contain the following information:

1. The results and date of the Appeal Determination;
2. The specific reason for the Adverse Determination in easily understandable language;
3. The titles and qualifications, including specialty, of the person or persons participating in the first level review process (Reviewer names are available upon request);
4. Reference to the evidence, benefit provision, guideline, protocol and/or other similar criterion on which the determination was based and notification that the Member on request can have a copy of the actual benefit provisions, guidelines, protocols and other similar criterion free of charge;
5. Notification the Member can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Member's benefit request;
6. Statement of the reviewer's understanding of the Member's Appeal;
7. The Reviewer's decision in clear terms and The Contract basis or medical rationale in sufficient detail for the Member to respond further;
8. Notification and instructions on how the Practitioner and/or Provider can contact the Physician or appropriate specialist to discuss the determination;
9. If the Adverse Determination is based on Medical Necessity or Experimental or Investigational Service or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the Certificate of Coverage to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
10. If applicable, instructions for requesting:
    a. A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Determination; or
    b. The written statement of the scientific or clinical rationale for the determination;
11. For Adverse Determinations of Prospective (Pre-service) or Retrospective (Post-service) Review a statement indicating:
    a. The written procedures governing the standard internal review, including any required timeframe for the review; and
    b. The Member's right to bring a civil action in a court of competent jurisdiction;
    c. Notice of the Member's right to contact the Division of Insurance for assistance at any time at:

       South Dakota Division of Insurance
       445 East Capitol Avenue
       Pierre, SD 57501-3185
       Phone: (605) 773-3563
       Fax: (605 773-5369

    d. Notice of the right to initiate the External Review process for Adverse Determinations based on Medical Necessity. Refer to "Independent, External Review of Final Determinations" in this Section for details on this process. Final Adverse Determination letters will contain information on the circumstances under which Appeals are eligible for External Review and information on how the Member can seek further information about these rights.
    e. If the Adverse Determination is completely overturned, the decision notice will state the decision and the date.

10.18 EXTERNAL PROCEDURES FOR ADVERSE DETERMINATIONS OF PHARMACEUTICAL EXCEPTION REQUESTS

Sanford Health Plan follows all requirements for denials and appeals as it relates to any Adverse Determination when there has been a Medical Necessity determination based on pharmacy service, certification of non-covered medication or Formulary design issue. This applies to requests for coverage of non-covered medications, generic substitution, therapeutic interchanges and step-therapy protocols.

External Exception Review (Appeal) of a Standard Exception Request:

- If we deny a request for a Standard Exception, the Member may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization.
- The Plan will make its determination on the External Exception Request and notify the Member or the Member's Authorized Representative, and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following the Plan's receipt of the request if the original request was a Standard Exception Request.
- If the Plan grants an External Exception Review of a Standard Exception Request, the Plan will provide coverage of the non-Formulary drug for the duration of the prescription.

External Exception Review (Appeal) of an Expedited (Urgent) Exception Request:

- If Sanford Health Plan denies a request for an Expedited Exception, the Member may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization.
- Sanford Health Plan will make its determination on the External Exception Request and notify the Member or the Member's Authorized Representative, and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours following our receipt of the request if the original request as an expedited exception.
- If Sanford Health Plan grants an External Exception Review of an Expedited Exception Request, we will provide coverage of the non- Formulary drug for the duration of the exigency.

10.19 STANDARD EXTERNAL REVIEW REQUEST PROCESSES & PROCEDURES

1. The Plan will follow the procedure for providing independent, external review of final determinations as outlined by federal ERISA regulations and rules governing the Plan in the Patient Protection and Affordable Care Act. Accordingly, an Independent External Review is not available for a Benefit Denial when it does not involve medical judgment.

NOTE: Adverse Benefit Determinations, e.g. denials that do not involve medical/clinical review, are not eligible for an External Review. The Plan's decision on Benefit Determinations is final and binding.

External Appeal Review Program – OVERVIEW

Members may file a request for External Review with Sanford Health Plan or with the South Dakota Division of Insurance at:

South Dakota Department of Revenue & Regulation
Division of Insurance
445 East Capitol Avenue
Pierre, SD 57501-3185
Phone: (605) 773-3563
Fax: (605 773-5369

An expedited Appeal procedure is used when the condition is an Urgent Care Situation, as defined previously in this Certificate of Coverage.

An expedited review involving Urgent Care Requests for Adverse Determinations of Pre-service or Concurrent claims must be utilized if the Member or Practitioner and/or Provider acting on behalf of the Member believe that an expedited determination is warranted. All of the procedures of a standard review described apply. In addition, for an Expedited Appeal, the request for an expedited review may be submitted. This can be done orally or in writing and the Plan will accept all necessary information by telephone or electronically. In such situations, the Practitioner who made the initial Adverse Determination may review the appeal and overturn the previous decision.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the appeal via oral notification by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than twenty-four (24) hours of receipt of the request. Sanford Health Plan will notify you orally by telephone or in writing by facsimile or via other expedient means. The Member and those Practitioners and/or Providers involved in the appeal will receive written notification within three (3) calendar days of the oral notification. If your claim is no longer considered urgent, it will be handled in the same manner as a Non-urgent Pre-service or a Non-urgent post-service appeal, depending upon the circumstances.

If the expedited review is a Concurrent Review determination, the service must be continued without liability to the Member until the Member or the representative has been notified of the determination.

10.20 EXTERNAL APPEAL REVIEW PROGRAM PROCEDURES

For independent, External Review of a final Adverse Determination, Sanford Health Plan will provide:

1. Members the right to an independent, third party, binding review whenever they meet the following eligibility criteria:

    a) The Member is Appealing an Adverse Determination that is based on Medical Necessity (benefits Adverse Determinations are not eligible);

    b) Sanford Health Plan has completed the internal Appeal review and its decision is unfavorable to the Member, or has exceeded the time limit for making a decision, or Sanford Health Plan has elected to bypass the available internal level of Appeal with the Member's permission;

c) The request for independent, External Review is filed within four (4) months of the date that Sanford Health Plan's Adverse Determination was made.

2. Notification to Members about the independent, External Review program and decision are as follows:
   a) General communications to Members, at least annually, to announce the availability of the right to independent, External Review.
   b) Letters informing Members and Practitioners of the upholding of an Adverse Determination covered by this standard including notice of the independent, External Appeal rights, directions on how to use the process, contact information for the independent, External Review organization, and a statement that the Member does not bear any costs of the independent, External Review organization, unless otherwise required by state law.

3. The External Review organization will communicate its decision in clear terms in writing to the Member and Sanford Health Plan. The decision will include:

   a) a general description of the reason for the request for external review;
   b) the date the independent review organization received the assignment from Sanford Health Plan to conduct the external review;
   c) the date the external review was conducted;
   d) the date of its decision;
   e) the principal reason(s) for the decision, including any, Medical Necessity rationale or evidence-based standards that were a basis for its decision; and
   f) the list of titles and qualifications, including specialty, of individuals participating in the appeal review, statement of the reviewer's understanding of the pertinent facts of the appeal and reference to evidence or documentation used as a basis for the decision.
   g) The External Review organization must also notify the Member how and when Members receive any payment or service in the case of overturned Adverse Determinations.

4. Conduct of the External Appeal Review program as follows:

   a) A Member will contact Sanford Health Plan with an external review request.
   b) Within five (5) business days following the date of receipt of the external review request, Sanford Health Plan shall complete a preliminary review of the request to determine whether:
   c) The Member is or was a covered person at the time the health care service was requested or, in the case of a Retrospective Review, was a covered person in the Plan at the time the health care service was provided;
   d) The health care service that is the subject of the Adverse Determination is a covered service under the Member's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness;
   e) The Member has exhausted Sanford Health Plan's internal Appeal process unless the Member is not required to exhaust Sanford Health Plan's internal Appeal process as defined above; and
   f) The Member has provided all the information and forms required to process an external review.

5. Within one (1) business day after completion of the preliminary review, Sanford Health Plan shall notify the Member and, if applicable, the Member's Authorized Representative in writing whether the request is complete and eligible for external review.

6. If the request is not complete, the NDID shall inform the Member and, if applicable, the Member's Authorized Representative in writing and include in the notice what information or materials are needed to make the request complete; or if the request is not eligible for external review, the NDID shall inform the

Member and, if applicable, the Member's Authorized Representative in writing and include the reasons for its ineligibility. If the Independent Review Organization upheld the denial, there is no further review available under this appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

7. If the request is complete, within one (1) business day after verifying eligibility, the NDID shall assign an independent review organization and notify in writing the Member, and, if applicable, the Member's Authorized Representative of the request's eligibility and acceptance for external review. The Member may submit in writing to the assigned Independent Review Organization within five (5) business days following the date of receipt of the notice provided by the NDID any additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after ten (10) business days.

8. Within five (5) business days after the date the NDID determines the request is eligible for external review, of receipt, the NDID shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final Adverse Determination.

9. The South Dakota Division of Insurance contracts with the independent, external review organization that:
   a) is accredited by a nationally recognized private accrediting entity;
   b) conducts a thorough review, in which it considers all previously determined facts; allows the introduction of new information; considers and assesses sound medical evidence; and makes a decision that is not bound by the decisions or conclusions of Sanford Health Plan or determinations made in any prior appeal.
   c) completes their review and issues a written final decision for non-urgent appeals within forty-five (45) calendar days of the request. For clinically Urgent Care appeals, the review and decision will be made and orally communicated as expeditiously as the Member's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. Within forty-eight (48) hours after the date of providing the oral notification, the assigned independent review organization will provide written confirmation of the decision to the Member, or if applicable, the Member's Authorized Representative, and their treating Practitioner and/or Provider.
   d) has no material professional, familial or financial conflict of interest with Sanford Health Plan.

10. With the exception of exercising its rights as party to the appeal, Sanford Health Plan must not attempt to interfere with the Independent Review Organization's proceeding or appeal decision.

11. Sanford Health Plan will provide the Independent Review Organization with all relevant medical records as permitted by state law, supporting documentation used to render the decision pertaining to the Member's case (summary description of applicable issues including Sanford Health Plan's decision, criteria used and clinical reasons, utilization management criteria, communication from the Member to Sanford Health Plan regarding the appeal), and any new information related to the case that has become available since the internal appeal decision.

12. The Member is not required to bear costs of the Independent Review Organization's review, including any filing fees. However, Sanford Health Plan is not responsible for costs associated with an attorney, physician or other expert, or the costs of travel to an independent, External Review hearing.

13. The Member or his/her legal guardian may designate in writing a representative to act on his/her behalf. A Practitioner and/or Provider may not file an Appeal without explicit, written designation by the Member.

14. The Independent Review Organization's decision is final and binding to Sanford Health Plan and Sanford Health Plan implements the Independent Review Organization's decision within the timeframe specified by the Independent Review Organization. The decision is not binding to the Member, because the Member has legal rights to pursue further appeals in court if they are dissatisfied with the outcome. However, a Member may not file a subsequent request for external review involving the same Adverse Determination for which the Member has already received an external review decision.

15. Sanford Health Plan maintains and tracks data on each appeal case, including descriptions of the denied item(s), reasons for denial, Independent, External Review organization decisions and reasons for decisions. Sanford Health Plan uses this information in tracking and evaluating its Medical Necessity decision-making process and improving the quality of its clinical decision making procedures. This information is reported to the Medical Management Quality Committee when a case is resolved for discussion and plan of care or action.

NOTE: All notifications and procedures described in this Section, in addition to those related to both Benefit and Medical Care Determinations in Section 2, will comply with applicable law. Should a conflict exist between Plan procedures and federal regulations, federal regulations shall control.

A complete description of your Complaint (Grievance) and Appeal Rights and the Appeal process will be included in determination responses and decisions made by Sanford Health Plan. Additionally, an overview of your Complaint (Grievance) and Appeal Rights, along with an Appeal Filing Form, is included in all Explanation of Benefits (EOBs) generated by Sanford Health Plan.

10.21 EXPEDITED EXTERNAL REVIEW REQUESTS

1. A Member or the Member's Authorized Representative may request an expedited external review of an Adverse Determination if the Adverse Determination involves an Urgent Care requests for Prospective (pre-service) or Concurrent Review request for which

    a. the timeframe for completion of a standard internal review would seriously jeopardize the life or health of the Member; or would jeopardize the Member's ability to regain maximum function; or
    b. in the case of a request for Experimental or Investigational Services, the treating Provider certifies, in writing, that the requested Health Care Services or treatment would be significantly less effective if not promptly initiated.

2. The Member has the right to contact the South Dakota Division of Insurance for assistance at any time at:

South Dakota Division of Insurance
445 East Capitol Avenue
Pierre, SD 57501-3185
Phone: (605) 773-3563
Fax: (605 773-5369

3. Immediately upon receipt of the request from the Member or the Member's Representative, the NDID shall determine whether the request is eligible for Expedited External Review. If the request is ineligible for an Expedited External Review as described in (1) above, the NDID will give notification to the Member or the Member's Representative that they may appeal to the state insurance department.

4. Upon determination that the Expedited External Review request meets the reviewability requirements, the NDID shall assign a contracted, independent review organization to conduct the expedited external review. The assigned independent review organization is not bound by any decisions or conclusions reached during Sanford Health Plan's utilization review or internal appeal process.

5. Sanford Health Plan will send all necessary documents and information considered in making the Adverse Determination to the assigned independent review organization electronically, by telephone, or facsimile or any other available expeditious method.

6. The independent review organization will make a decision to uphold or reverse the adverse determination and provide oral notification to the Member, and, if applicable, the Member's Authorized Representative, and the treating Practitioners and/or Providers as expeditiously as the Member's medical condition or circumstances requires but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. The Member and those Practitioners and/or Providers involved in the appeal will receive written notification within forty-eight (48) hours of the oral notification.

7. At the same time a Member, or the Member's Authorized Representative, files a request for an internal Expedited Review of an Appeal involving an Adverse Determination, the Member, or the Member's Authorized Representative, may also file a request for an external Expedited External Review if the Member has a medical condition where the timeframe for completion of an expedited review would seriously jeopardize the life or health of the Member or would jeopardize their ability to regain maximum function; or if the requested health care service or treatment is an Experimental or Investigational Service and the Member's treating Practitioner and/or Provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the Adverse Determination would be significantly less effective if not promptly initiated.

8. Upon Sanford Health Plan's receipt of the independent review organization's decision to reverse the Adverse Determination, Sanford Health Plan shall immediately approve the coverage that was the subject of the Adverse Determination

SECTION 11
DEFINITIONS OF TERMS WE USE IN THIS CERTIFICATE OF COVERAGE

Adverse Determination	Any of the following determinations: The denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination of a Member's eligibility to participate in the Plan; Any prospective review or retrospective Utilization Review determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit; or A rescission of coverage determination.
Affordable Care Act or ACA	The Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.
Ambulatory Surgical Center	A lawfully operated, public or private establishment that: • Has an organized staff of Practitioners; • Has permanent facilities that are equipped and operated mostly for performing surgery; • Has continuous Practitioner services and Nursing Services when a Member is in the Facility; and • Does not have services for an overnight stay.
Approved Clinical Trial	A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following: • A federally funded or approved trial; • A clinical trial conducted under an FDA investigational new drug application; or • A drug trial that is exempt from the requirement of an FDA investigational new drug application
Authorized Representative	A person to whom a Member has given express written consent to represent the Member, a person authorized by law to provide substituted consent for a Member, a family member of the Member or the Member's treating health care professional if the Member is unable to provide consent, or a health care professional if Sanford Health Plan requires that a request for a benefit be initiated by the health care professional. For any Urgent Care Request, the term includes a health care professional with knowledge of the Member's medical condition.
Avoidable Hospital Conditions	Conditions that could reasonably have been prevented through application of evidence-based guidelines. These conditions are not present on admission, but present during the course of the stay. Participating Providers are not permitted to bill Sanford Health Plan or Members for services related to Avoidable Hospital Conditions.
Calendar Year	A period of one year which starts on January 1st and ends December 31st.
Case Management	A coordinated set of activities conducted for individual Member management of chronic, serious, complicated, protracted, or other health conditions.

Certification	Certification is a determination by Sanford Health Plan that a request for a benefit has been reviewed and, based on the information provided, satisfies Sanford Health Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, and effectiveness.
Coinsurance	The percentage of charges to be paid by a Member for Covered Services after the Deductible has been met.
Concurrent Review	Concurrent Review is Utilization Review for an extension of previously approved, ongoing course of treatment over a period of time or number of treatments typically associated with Hospital Inpatient care, including care at a Residential Treatment Facility, and ongoing outpatient services, including ambulatory care.
[This] Contract or [The] Contract	The contract between Sanford Health Plan and the Group including this Certificate of Coverage, (including all attachments, amendments and addenda), the Group's application, the applications of the Subscribers and the Health Maintenance Contract.
Copay	An amount that a Member must pay at the time the Member receives a Covered Service.
Cost Sharing	An amount the Member must pay for Covered Services. Cost Sharing can be in the form of a Copay, Coinsurance or Deductible.
Covered Services	Those Health Care Services for which a Member is entitled to benefits under the terms of This Contract.

Creditable Coverage	Benefits or coverage provided under: • Medicare or Medicaid; • An employer-based health insurance plan or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a health benefit plan; • An individual health insurance policy; • Chapter 55 of Title 10, United States Code; • A medical care program of the Indian Health Service or of a tribal organization; • A state health benefits risk pool; • A health plan offered under Chapter 89 of Title 5, United States Code; • A public health plan; • A health benefit plan under §5(e) of the Peace Corps Act (22 U.S.C. 2504)(e)); • College plan; or • A short-term limited-duration policy.
Deductible	The amount that a Member must pay each Calendar Year before Sanford Health Plan will pay benefits for Covered Services
Dependent	The Spouse and any Dependent Child.
Dependent Child(ren)	A Subscriber's biological child; • A child lawfully adopted by the Subscriber or in the process of being adopted, from the date of placement; • A stepchild of the Subscriber; or • A foster child or any other child for whom the Subscriber has been granted legal custody
Eligible Dependent	Any Dependent who meets the specific eligibility requirements of the Group's health benefit plan
Eligible Group Member	Any Group Member who meets the specific eligibility requirements of the Group's health benefit plan
Emergency Medical Condition	Sudden and unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.
ESRD	The Federal End Stage Renal Disease program.

Expedited Appeal	An expedited review involving Urgent Care Requests for Adverse Determinations of Prospective (Pre-service) or Concurrent Reviews will be utilized if the Member, or Practitioner and/or Provider acting on behalf of the Member, believes that an expedited determination is warranted.
Experimental or Investigational Services	Health Care Services where the Health Care Service in question either: • is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or • requires approval by any governmental authority and such approval has not been granted prior to the service being rendered.
Facility	An institution providing Health Care Services or a health care setting, including Hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, Residential Treatment Facilities, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings.
Formulary	A list of covered prescription drugs, both generic and brand name maintained by Sanford Health Plan and applicable to this Certificate of Coverage.
[The] Group	The entity that sponsors this health maintenance agreement as permitted by SDCL-58-41 under which the Group Member is eligible and enrolled. Also known as the Plan Sponsor and Administrator.
Group Member	Any employee, sole proprietor, partner, director, officer or Member of the Group.
Health Care Services	Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease. Health Care Services may include medical evaluations, diagnosis, treatment, procedures, drug, therapies and supplies.
Hospital	A short-term, acute care, duly licensed institution that is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians. It has organized departments of medicine and/or major surgery and provides 24-hour nursing service by or under the supervision of registered nurses. The term "Hospital" specifically excludes rest homes, places that are primarily for the care of convalescents, nursing homes, skilled nursing facilities, Residential Care Facilities, custodial care homes, intermediate care facilities, health resorts, clinics, Physician's offices, private homes, Ambulatory Surgical Centers, residential or transitional living centers, or similar facilities
Hospitalization	A stay as an inpatient in a Hospital. Each "day" of Hospitalization includes a stay for which a charge is customarily made. Benefits may not be restricted in a way that is based upon the number of hours that the Member stays in the Hospital.
Iatrogenic Condition	Illness or injury because of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error.
In-Network Benefit Level	The upper level of benefits provided by Sanford Health Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Participating Practitioner and/or Provider designated by Sanford Health Plan, in its sole discretion, as part of this Certificate of Coverage's defined network.

In-Network Coverage	In-Network Coverage means Covered Services that are either received:
	• from an In-Network Participating Practitioner and/or Provider within the Service Area; or
	• from a Participating Provider outside of the Service Area if an In-Network Participating Practitioner and/or Provider has recommended the referral, and
	  • Sanford Health Plan has authorized the referral to a Participating Provider outside of the Service Area or
	  • Sanford Health Plan has authorized the referral from a In-Network Participating Practitioner and/or Provider to a Non-Participating Provider or Out-of-Network Participating Provider; or
	• when experiencing an Emergency Medical Condition or in an Urgent Care Situation; or
	• when the Member does not have appropriate access to In-Network Participating Practitioner and/or Provider.

In-Network Facility	A Facility (as defined above) considered "In-Network" by the terms of this Certificate of Coverage.
In-Network Pharmacy	A Pharmacy considered "In-Network" by the terms of this Certificate of Coverage.
In-Network Participating Practitioner and/or Provider	A Participating Practitioner and/or Provider that is considered "In-Network" by the terms of this Certificate of Coverage.
Intensive Outpatient Program (IOP)	Provides mental health and/or substance use disorder outpatient treatment services during which a Member remains in the program a minimum of three (3) continuous hours per day and does not remain in the program overnight. Programs may be available in the evenings or weekends.
Long-Term Residential Care	The provision of long-term diagnostic or therapeutic services (i.e., assistance or supervision in managing basic day-to-day activities and responsibilities) to Members with physical, mental health and/or substance use disorders. Care may be provided in a long-term residential environment known as a transitional living Facility; on an individual, group, and/or family basis; generally provided for persons with a lifelong disabling condition(s) that prevents independent living for an indefinite amount of time
Maintenance Care	Treatment provided to a Member whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Practitioner and/or Provider.

Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for Covered Services and supplies. Sanford Health Plan's Maximum Allowable Amount is the lesser of:
	• the amount charged for a Covered Service or supply; or
	• inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or
	• outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable:
	  • Fees typically reimbursed to providers for same or similar professionals; or
	  • Costs for facilities providing the same or similar services, plus a margin factor.

Medically Necessary or Medical Necessity	Health Care Services that are appropriate and necessary as determined by any Participating Provider, in terms or type, frequency, level, setting, and duration, according to the Member's diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must be consistent with generally accepted standards of medical practice as recognized by Sanford Health Plan, as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and • help restore or maintain the Members health; or • prevent deterioration of the Member's condition; or • prevent the reasonably likely onset of a health problem or detect an incipient problem; or • not considered Experimental or Investigative Service
Member	Any individual who is enrolled in the Plan.
Mental Health and Substance Use Disorder Services	Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD), current editions. Also referred to as behavioral health, psychiatric, chemical dependency, substance abuse, and/or addiction services.
Natural Teeth	Teeth, which are whole, without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury
Never Event	Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a problem in the safety and credibility of a health care Facility. Participating Providers are not permitted to bill Sanford Health Plan or Members for services related to Never Events
Non-Covered Services	Health Care Services that are not part of benefits paid for by the Plan.
Non-Participating Provider	Non-Participating Provider: A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.

Nursing Services	Health Care Services which are provided by a registered nurse (RN), licensed practical nurse (LPN), or other licensed nurse who is: (1) acting within the scope of that person's license, (2) authorized by a Provider, and (3) not a Member of the Member's immediate family.
Open Enrollment or Open Enrollment Period	A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan
Out-of-Network Benefit Level	The lower level of benefits provided by Sanford Health Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Non-Participating Practitioner and/or Provider or a Participating Practitioner and/or Provider not designated in the network as defined by the terms of this Certificate of Coverage.
Out-of-Network Participating Practitioner and/or Provider	A Participating Practitioner and/or Provider that is considered "Out-of-Network" by the terms of this Certificate of Coverage
Out-of-Pocket Maximum Amount	The total Copay, Deductible and Coinsurance Amounts for certain Covered Services that are a Member's responsibility each calendar year. When the Out-of-Pocket Maximum Amount is met, the Plan will pay 100% of the reasonable costs for Covered Services. The Out-of-Pocket Maximum Amount resets on January 1 of each calendar year. Medical and prescription drug Copay amounts apply toward the Out-of-Pocket Maximum Amount.
Participating Provider or Participating Pharmacy	A Practitioner and/or Provider who, under a contract with Sanford Health Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, directly or indirectly, from Sanford Health Plan.
Partial Hospitalization Program	Also known as day treatment; A licensed or approved day or evening outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for individuals with mental health and/or substance use disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment with such program lasting a minimum of six (6) or more continuous hours per day.
Physician	An individual licensed to practice medicine or osteopathy.
[The] Plan	The group health plan maintained by the Group.
Plan Year	A twelve (12) month period beginning on the effective date.
Practitioner	A professional who provides health care services. Practitioners are usually required to be licensed, as required by law. Practitioners are also Physicians.
Prospective (Pre-service) Review	Means urgent and non-urgent Utilization Review conducted prior to an admission or the provision of a health care service or a course of treatment.
Prudent Layperson	A person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek medical treatment for an Emergency.

Preventive	Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan.
Primary Care Physician (PCP)	A Participating Provider who is an internist, family practice Physician, pediatrician, or obstetrician/gynecologist who is a Participating Practitioner and who has been chosen to be designated as a Primary Care Physician as indicated in the Provider Directory and may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Member.
Provider	An institution or organization that provides services for Members. Examples of Providers include Hospitals and home health agencies.
Qualifying Event	A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby) and gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder.
Reduced Payment Level	The lower level of benefits provided by The Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Participating or Non-Participating Provider without certification or prior-authorization when certification/prior-authorization is required.
Residential Treatment Facility	An inpatient mental health or substance use disorder treatment Facility that provides *twenty-four (24)* hour availability of qualified medical staff for psychiatric, substance abuse, and other therapeutic and clinically informed services to individuals whose immediate treatment needs require a structured *twenty-four (*24) hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, substance abuse education/counseling. Facilities must be under the direction of a board-eligible or certified psychiatrist, with appropriate staffing on-site at all times. If the Facility provides services to children and adolescents, it must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children. Hospital licensure is required if the treatment is Hospital-based. The treatment Facility must be licensed by the state in which it operates.
Retrospective (Post-service) Review	Means any review of a request for a benefit that is not a Prospective (Pre-service) Review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication of payment. Retrospective (Post-service) Review will be utilized by Sanford Health Plan to review services that have already been utilized.
Service Area	The geographic Service Area identified in this Certificate of Coverage.
Service Charge or Premium	The amount paid by the Group to Sanford Health Plan on a monthly basis for coverage for Members under this Contract.

Special Enrollment Period	A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. In the Marketplace, you qualify for a special enrollment period 60 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other health coverage. Job-based plans must provide a special enrollment period of 30 days.
Spouse	An individual who is a Subscriber's current lawful Spouse.
Subscriber	An Eligible Group Member who is enrolled in the Plan. A Subscriber is also a Member.
[This] State	The State of South Dakota.
Summary of Benefits and Coverage or SBC	Attachment I of this Contract that sets forth important information on coverage and Cost Sharing.
Utilization Review	A set of formal techniques used by Sanford Health Plan to monitor and evaluate the Medical Necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Prospective (pre-service) Review, second opinion, Certification, Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review.
Urgent Care Request	Means a request for a Health Care Services or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination: 1. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or 2. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the Health Care Services or treatment that is the subject of the request.
Us/We	Refers to Sanford Health Plan
You	Refers to the Subscriber or Member, as applicable.

ATTACHMENT I. SUMMARY OF BENEFITS AND COVERAGE

This page is intentionally left blank. Your Summary of Benefits and Coverage is an attachment to this Certificate of Coverage.