SANFORD HEALTH PLAN

Member Rights and Responsibilities

Member Rights

The Plan is committed to treating members in a manner that respects their rights. In this regard, the 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:

1. Members have the right to refuse treatment.
2. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; gender; gender identity; sexual orientation; medical condition; including current or past history of a mental health and substance use disorder; disability; religious beliefs; national origin; age; or sources of payment for care.
3. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
4. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
5. 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.
6. 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 South Dakota, North Dakota, Minnesota, and Iowa law.
7. Members have the right to know the identity and professional status of individuals providing service to them and to know which physician or other practitioner is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
8. Members have the right to a candid discussion with the practitioner(s) and/or Provider(s) 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.
9. Members have the right to give informed consent before the start of any procedure or treatment.
10. When Members do not speak or understand the predominant language of the community, the Plan will provide access to an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the member.
11. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and read.
12. 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.
13. Members have the right to appeal any decision regarding medical necessity made by the Plan and its practitioners and/or providers.
14. Members have the right to terminate coverage under the Plan, in accordance with applicable Employer and/or Plan guidelines.

15. Members have the right to make recommendations regarding the organization's member's rights and responsibilities policies.
16. Members have the right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities policies.
17. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, or the use of restraints and seclusion.

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:

1. 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 practitioner. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
2. Members are responsible for carrying their Plan ID cards with them and for having member identification numbers available when telephoning or contacting the Plan, or when seeking health care services.
3. Members are responsible for following all access and availability procedures.
4. Members are responsible for seeking emergency care at a Plan participating emergency facility whenever possible. In the event an ambulance is used, members are encouraged to direct the ambulance to the nearest participating emergency facility unless the condition is so severe that you must use the nearest emergency facility. State laws require that the ambulance transport you to the hospital of your choice unless that transport puts you at serious risk.
5. Members are responsible for notifying the Plan of an emergency admission as soon as reasonably possible and no later than forty-eight (48) hours after becoming physically or mentally able to give notice or as soon as reasonably possible.
6. 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.
7. 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 care conditions, including mental health and/or substance use disorders.
8. Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
9. Members are responsible for providing name, address, or telephone number changes within thirty (30) days. Members who purchased an Individual plan should call Sanford Health Plan at (800) 752-5836 (TTY: 711). Members with an employer group plan must notify their employer/Plan Sponsor, who is responsible for notifying the Plan.
10. Members are responsible for reporting any changes of eligibility that may affect their membership or access to services. Members who purchased an Individual plan should call Sanford Health Plan at (800) 752-5836 (TTY: 711). Members with an employer group plan must notify their employer/Plan Sponsor, who is responsible for notifying the Plan.

For Minnesota Enrollees

Important Enrollee Information

The HMO coverage described in this Policy may not cover all your health care expenses. Read this Policy carefully to determine which expenses are covered.

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

1. COVERED SERVICES. Services provided by SHP will be covered only if services are provided by participating SHP providers or authorized by SHP. Your Policy fully defines what services are covered and describes procedures you must follow to obtain coverage.
2. PROVIDERS. Enrolling in SHP does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the SHP network, you must choose from remaining SHP network providers.
3. REFERRALS. Certain services are covered only upon referral. See your Policy for referral requirements. All referrals to non-SHP network providers and certain types of health care providers must be authorized by SHP.
4. EMERGENCY SERVICES. Emergency services from providers who are not affiliated with SHP will be covered. Your Policy explains the procedures and benefits associated with emergency care from SHP network and non-SHP network providers.
5. EXCLUSIONS. Certain service or medical supplies are not covered. You should read the Policy for a detailed explanation of all exclusions.
6. CONTINUATION. You may convert to an individual health maintenance organization contract or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your Policy.
7. CANCELLATION. Your coverage may be canceled by you or SHP only under certain conditions. Your Policy describes all reasons for cancellation of coverage.
8. NEWBORN COVERAGE. If your health plan provides for dependent coverage, a newborn infant is covered from birth, but only if services are provided by participating SHP network providers or authorized by SHP. Certain services are covered only upon referral. SHP will not automatically know of the infant's birth or that you would like coverage under your plan. You should notify SHP of the infant's birth and that you would like coverage. If your Policy requires an additional premium for each dependent, SHP is entitled to all enrollment premiums due from the time of the infant's birth until the time you notify SHP of the birth. SHP may withhold payment of any health benefits for the newborn infant until any premiums you owe is paid.
9. PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT. Enrolling in SHP does not guarantee that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the Policy year.

ENROLLEE BILL OF RIGHTS (Minnesota Only)

1. Enrollees have the right to available and accessible services including emergency services, as defined your contract, 24 hours a day and seven days a week.
2. Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice.
3. Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law.
4. Enrollees have the right to file a complaint with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers.

5. Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force.
6. Medicare enrollees have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law.
7. Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.