North Dakota

Individual TRUE

Certificate of Coverage

Help understanding this document is free.
If you would like this Certificate of Coverage 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 *(toll-free)* to connect with us using free translation services.

SANFORD
HEALTH PLAN

Welcome to Sanford Health Plan

Welcome to Sanford Health Plan. We are pleased to have you as a Member and look forward to providing you and your enrolled Dependents with Health Care Services.

In exchange for your completed application, and payment of the Premium as shown on your application, we will pay benefits of this Certificate of Coverage according to its provisions.

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.

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

Individual Certificate of Coverage

Renewal Provision

Coverage under this Contract is guaranteed renewable at the discretion of the Subscriber except as permitted to be canceled, rescinded, or not renewed under applicable Law and as described in Section 2 *How Coverage Ends*. To keep the Certificate of Coverage in force, you must pay each Premium on its due date or within the grace period. We may change the Premium annually, but only if we change the Premium for all contracts of this product type.

Right to Cancel and Return Your Contract

We want you to be satisfied with this Contract. If you are not satisfied, you may cancel it within ten (10) calendar days after receiving it by mail or delivering it to us. If returned, the Contract will be considered void from the original effective date and we will refund any Premiums paid. If we have paid claims for you during this inspection period, we have the right to recover any amounts we paid.

Disclaimer

The ACA includes provisions to lower Premiums and reduce Cost Sharing for individuals with low to modest incomes through advance payment of premium tax credits and Cost Sharing reductions. Such affordability programs are available only for qualifying individuals who purchase health insurance coverage through the Federal Marketplace. Please be advised that this Contract will only qualify for these affordability programs if it is obtained and issued through the Federal Marketplace.

How to Contact Us

If you have any questions about provisions of this Certificate of Coverage, please write or call:
Sanford Health Plan
300 Cherapa Place, Suite 201
PO Box 91110
Sioux Falls, SD 57103
Phone: (877) 305-5463 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*

Certificate of Coverage
Table of Contents

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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.

Free Help in Other Languages

This Certificate of Coverage replaces any prior Certificate of Coverage 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 *(toll-free)*. Both oral and written translation services are available for free in at least one-hundred-fifty (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

.Sanford Health Plan قماه تامولعم راعشلا اذه يوحي.للاخ نم قيطعتلا بلع لوصحلل كبلط صوصخب قمهم تامولعم راعشلا اذه يوحي
راعشلا اذه يف قماهلا خيراوتلا نع ثحبا.عفد يف قدعاسملل وا تيحصلا كتيطعت بلع ظافحلل قتيعم خيراوت يف ءارجا ذاختلا جاتحت دق
فيلاكتلا.قفلكت يأ نود نم كتغلب قدعاسملاو تامولعملا بلع روصحلا يف قحلا كل .بـ 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.

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。

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 ।**

French

Cet avis a dimportantes informations. Cet avis a dimportantes informations sur votre demande ou la couverture par lintermédiaire 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 daide avec les coûts. Vous avez le droit dobtenir 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 커버리지에 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.

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 of Privacy Practices ("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. 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 Physician 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 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.
- **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.
- **Workers' compensation and other government requests**: We can share information to employers for workers' 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) calendar 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 online at www.sanfordhealthplan.com.

EFFECTIVE DATE

This Notice of Privacy Practices is effective January 1, 2020.

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

Sanford Health Plan is ready to help Monday through Friday, 8:00 a.m. to 5:00 p.m. CST and a confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day. A thorough understanding of your coverage will enable you to use your benefits wisely. If you have any questions, please contact Sanford Health Plan using the information below.

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

1. 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.
2. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
3. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. 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.
5. 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 North Dakota law.
6. 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.
7. Members have the right to obtain complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis in a way that is understandable from the Providers responsible for coordinating their care, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with Providers in decision making regarding their treatment planning.
8. Members have the right to give informed consent before the start of any procedure or treatment.
9. When Members do not speak or understand the predominant language of the community, Sanford Health Plan will make reasonable 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.
10. Members have the right to receive printed materials that describe important information about their coverage in a format that is easy to understand and easy to read.
11. 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.
12. Members have the right to Appeal any decision regarding Medical Necessity made by Sanford Health Plan.
13. Members have the right to terminate from coverage, in accordance with Sanford Health Plan guidelines.
14. Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
15. 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:

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 ID cards with them and for having Member identification numbers available when telephoning or contacting Sanford Health Plan.
3. Members are responsible for following all access and availability procedures.
4. 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 In-Network 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.
5. Members are responsible for notifying Sanford Health 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.
6. Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible Provider 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, to the degree possible, in understanding their health care problems including behavioral problems and developing mutually agreed-upon treatment goals.
8. Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
9. Members are responsible for notifying Sanford Health Plan within thirty (30) calendar days at (800) 752-5863 *(toll-free)* or TTY/TDD: (877) 652-1844 *(toll-free)* if they change their name, address, or telephone number.
10. Members are responsible for notifying Sanford Health Plan of any changes of eligibility that may affect their membership or access to services.

Authorized Certificate of Coverage Changes

No agent, employee, or representative of Sanford Health Plan is authorized to vary, add to, change, modify, waive or alter any of the provisions of this Certificate of Coverage. This Certificate of Coverage cannot be changed except by:

1. Written amendment signed by one of our authorized officers and accepted by you as shown by payment of the Premium. Your acceptance of the amendment must be in writing if the amendment:
   a. reduces or eliminates benefits; or
   b. increases benefits and is accompanied by an increase in Premium during the Certificate of Coverage term, unless the increase in benefits is required by law.
2. Written amendment in which we exercise a right specifically reserved under this Certificate of Coverage that is signed by one of our authorized officers and mailed to you and accepted by you as shown by payment of the Premium.

If we receive written notification that your marital or dependent status has changed and we receive an appropriate Premium in advance, then we will change your coverage to the correct coverage type. See *Types of Coverage* explained in Section 1.

Governing Law

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

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 void this application or Certificate of 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 Certificate of Coverage.

Legal Action

You may not start legal action regarding a claim that we have denied under this Certificate of Coverage unless you have exhausted the Appeal process described in Section 9, *Problem Resolution*.

No legal or equitable action may be brought for payment of benefits under this Contract prior to the expiration of sixty (60) calendar days following Sanford Health Plan's receipt of a claim for benefits or later than three (3) years after written proof of loss is required to be furnished.

Premium Refund in the Event of Death

In the event of the death of the Member, Sanford Health Plan will refund within thirty (30) calendar days after receiving notice of the Member's death the portion of the Premium paid beyond the month of death after deducting any claim for losses during the current term of the Certificate of Coverage. This provision does not apply if Sanford Health Plan has a valid defense to the payment of benefits under the Certificate of Coverage.

Disclosure Statement

You hereby expressly acknowledge your notice that this Certificate of Coverage is a contract solely between you, the Member, and us, Sanford Health Plan. You, the Member, further acknowledge and agree that you have purchased this Certificate of Coverage based upon representations by our authorized representatives or us. No other person, entity, or organization other than us is accountable or liable to you for any obligations created under this Certificate of Coverage. This paragraph does not create any additional obligations whatsoever on our part other than those obligations created under the provisions of this Certificate of Coverage.

Service Area

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

Medical Terminology

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

Definitions

Capitalized terms are defined in Section 10 of this Certificate of Coverage.

Conformity with State and Federal Laws

Any provision in this Certificate of Coverage not in conformity with North Dakota Century Code chapters 26.1-18.1 and 26-1-36, North Dakota Administrative Code chapter 45-06-07, or any other applicable Law may not be rendered invalid, but be construed and applied as if it were in full compliance with any applicable Law.

Special Communication Needs

Please call Sanford Health Plan if you need help understanding written information at (800) 752-5863 *(toll-free)*. We can read forms to you over the phone and we offer free oral translation in any language through our translation services.

Translation Services

Sanford Health Plan can arrange for translation services. Free written materials are available in several different languages and free oral translation services are available. Call toll-free (800) 752-5863 *(toll-free)* for help and to access translation services. For more information, see the section entitled *Free Help in Other Languages* at the beginning of this Certificate of Coverage.

Services for the Deaf, Hearing Impaired, and/or Visually Impaired

If you are deaf or hearing impaired, and would like to speak to Sanford Health Plan, call TTY/TDD: (877) 652-1844 *(toll-free)*.
Please contact Sanford Health Plan toll-free at (800) 752-5863 *(toll-free)* if you are in need of a large print copy or cassette/CD of any of Sanford Health Plan's written materials.

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 Health Care Services 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 *(toll-free)*. All calls are strictly confidential.

Clerical Error

Any clerical error by Sanford Health Plan or an agent of Sanford Health Plan 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 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.

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 Non-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 Contract, as well as any attachments or amendments appended hereto, or pursuant to applicable Law, a suit for benefits under this Contract 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 3 and 9 of this Certificate of Coverage for applicable timelines, and details, on appealing an Adverse Determination.

Notice of Non-Discrimination

In compliance with 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 Premium.

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 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 contact our Civil Rights Coordinator.

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

Types of Coverage

IMPORTANT INFORMATION: The terms of your coverage are defined in the documents that make up your Contract. Your Contract includes this Certificate of Coverage (including all attachments, amendments and addenda), the enrollment letter, the application(s) submitted by the Subscriber, the Summary of Benefits and Coverage, and the Pharmacy Handbook. All of the statements made by you in any submitted materials will be treated by us as representations, not warranties.

There are two different types of coverage you may hold under this Contract.

- Single coverage means the Member is the only one covered. This may include child-only policies.
- Family coverage means the Member, his or her Spouse and each of his or her Dependent Children has coverage. Each Dependent must be listed on the Member's application for coverage or added later as a new covered person.

The internal claims and Appeals process set forth in Section 7, *Problem Resolution* of this Certificate of Coverage covers initial eligibility determination under this Certificate of Coverage.

Premiums

You must pay us in advance each calendar month for the duration of your Contract. The payment must meet the Premium requirements for that month.

Grace Period.

- For coverage that was purchased outside of the Federal Marketplace and coverage that was purchased through the Federal Marketplace and the Subscriber that does not receive federal advance payments of the premium tax credits: A grace period of thirty-one (31) calendar days following the Premium payment due date will be allowed for the payment of any Premium, after the first Premium is paid. During the grace period this Contract shall continue in force. If the Premium is not paid on or before the end of the grace period, coverage will terminate at the end of the last day of the grace period. However, we may deduct the applicable Premium amount from any claims we pay during the grace period.
- For coverage that was purchased through the Federal Marketplace and the Subscriber receives federal advance payments of the premium tax credits: A grace period of three (3) months, following the Premium payment due date will be allowed for the payment of any Premium after the first Premium is paid. During this three (3) month grace period, we will pay claims for Covered Services rendered during the first month of the grace period and may pend claims for Covered Services rendered in the second and third months of the grace period. We will notify the Federal Marketplace of the non-payment of Premium and will notify health care Providers of the possibility for denied claims during the second and third months of the grace period. If the Premium is not paid on or before the end of the grace period, coverage will terminate at the end of the last day of the first month of the three (3) month grace period. However, we may deduct the applicable Premium amount from any claims we pay during the grace period.

Reinstatement. If you fail to pay any monthly Premium within the thirty-one (31) day grace period (three (3) months for Members who receive federal advance payment of the premium tax credits), your coverage will lapse. You may request reinstatement of this Certificate of Coverage by submitting an application for reinstatement to us. We may approve or disapprove your application. You will be notified by us in writing of our decision on your application for reinstatement. If we do not notify you of our disapproval within forty-five (45) calendar days of the date you submitted your application for reinstatement to us, this Certificate of Coverage will be reinstated upon the forty-fifth calendar day following our receipt of your application for reinstatement and your Premium payment due. If reinstated, this Certificate of Coverage will only cover claims for Covered Services that occurred after the date of reinstatement.

Premium Changes. We have the right to change your Premium on an annual basis upon our implementation of a new table of rates or an increase in your age. If we do change your Premium, we will notify you at least sixty (60) calendar days before the change.

Term and Renewal

This Certificate of Coverage will be in force from the effective date until the following December 31st. The Certificate of Coverage is subject to all terms, conditions, exclusions and limitations set forth in the Contract including the requirement that Premium be paid within the grace period. If your Certificate of Coverage is not terminated by you or by us, we will renew your Certificate of Coverage for the next Calendar Year. See Section 2, *How Coverage Ends* for information on how the Certificate of Coverage may be terminated by you or by us.

When Coverage Begins

This Certificate of Coverage becomes effective at 12:01 a.m. (One minutes after Midnight), Central Time, on the date shown on your application and your enrollment letter. Coverage begins on the day this Certificate of Coverage goes into effect.

If you are an inpatient in a Hospital or other Facility on the day your coverage begins, we will pay benefits for Covered Services that you receive beginning on the date your coverage becomes effective, as long as you receive Covered Services in accordance with the terms of this Certificate. Payment of benefits is subject to any obligations under a previous plan or coverage arrangement in accordance with applicable Law. If an extension under any prior coverage exists on the date coverage is effective under this Certificate of Coverage, Sanford Health Plan coordinates benefits. For more information, see Section 2, *Continuation of Coverage for Confined Members* and Section 7, *Coordination of Benefits*.

NOTE: Before you receive benefits under this Certificate of Coverage, you have agreed in your application to release any necessary information requested about you so we can process claims for benefits. You must allow any health care Provider, Facility, or their employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information in your application, your benefits may be denied.

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 void the application for coverage or this Certificate of Coverage, and to deny claims.

Eligibility Requirements

To be eligible to enroll for coverage under this Contract, you must be a Subscriber or Dependent, and meet the following eligibility requirements.

Subscriber Eligibility
To be eligible for coverage the Subscriber must be enrolled in coverage through the Federal Marketplace or meet the eligibility requirements listed below at the time of application and throughout the Policy Year.

1. Maintain a physical place of residence within the North Dakota Counties of Traill, Cass, Oliver, Burleigh, or Morton, and may be required to submit documents to prove North Dakota residency;
2. Complete an application form;
3. the North Dakota Counties of Traill, Cass, Oliver, Burleigh, or Morton within 30 days so they may be moved to an eligible plan;
4. Agree to abide by the terms of this Contract; and
5. Submit proof satisfactory to us to confirm Dependent eligibility.

Dependent Eligibility
The following Dependents are eligible for coverage ("Dependent coverage"):
Spouse – the Subscriber's Spouse is eligible for coverage, 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:

1. 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; and
2. Be one of the following:
   a. under age twenty-six (26); or
   b. incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Subscriber for support and maintenance. If Sanford Health Plan so requests, the Subscriber must provide proof of the Dependent Child's disability within thirty-one (31) calendar days of Sanford Health Plan's request. Such a request may be no more than annually following the two (2) year period of the Dependent Child's attainment of the limiting age.

Dependent of Dependent Child - To be eligible for coverage, the 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:

a. natural child of a Dependent Child;
b. child placed with a Dependent Child for adoption;
c. child legally adopted by a Dependent Child;
d. child for whom a Dependent Child has legal guardianship;
e. stepchild of a Dependent Child; or
f. foster child of a Dependent Child.

NOTE: Dependent coverage does not include the spouse of an adult Dependent child. Until the Dependent Child attains the age of twenty-six (26), the Dependent Child's marital status, financial dependency, residency, student status or employment status will not be considered in determining eligibility for initial or continued coverage.

NOTE: All Dependents must reside within the North Dakota Counties of Traill, Cass, Oliver, Burleigh, or Mortonto be eligible for coverage under this Certificate of Coverage. An Eligible Dependent must reside in one of the listed counties for the duration of their Plan Year for services to be covered.

It is the Subscriber responsibility to inform Sanford Health Plan if any Dependent or Member moves outside one of these counties so the Member and their Dependents can be moved to an eligible plan. Failure to inform Sanford Health Plan of a move could result in a denial or reduction of benefits.

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.

Qualified Medical Child Support Order (QMCSO) Provision

A QMCSO is an order of a court or administrative tribunal that creates the right of a Subscriber's Dependent Child to be enrolled 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 that Sanford Health Plan is in receipt of a QMCSO which contains the following required information:

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

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, payments, and other materials.

Exceptions. If a court has ordered a Subscriber to provide health coverage for a Dependent Child, the requirements in the sections above on Dependent Children 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 or legal representative of the Dependent Child 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; or
2. The Dependent Child is 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.

How to Enroll Dependents

Dependents may be enrolled during the annual Open Enrollment Period or during a Special Enrollment Period.

1. For coverage purchased on the Federal Marketplace, the Subscriber must contact the Federal Marketplace during the Special Enrollment Period.
2. For coverage purchased outside the Federal Marketplace, the Subscriber must:
   a. Submit a request to us before any applicable enrollment deadline;
   b. Agree to pay the required additional Premium, if any; and
   c. Complete and sign an enrollment application form requesting coverage for the Dependent.

You will be provided with prior written notice of the annual Open Enrollment Period each Calendar Year.

When Dependent Coverage Begins

1. **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 as described in above under *When Coverage Begins*.
2. **Delayed Effective Date of Dependent Coverage**
   Except for newborns (see "Coverage from Birth" below), if, on the date Dependent coverage becomes effective, the Dependent is Hospitalized and covered under an extension of health benefits from a previous group health plan or other coverage arrangement, coverage under this Contract shall be subject to benefits payable under the previous plan or coverage arrangement. If an extension under any prior coverage exists, Sanford Health Plan coordinates benefits.
3. **Coverage from Birth**
   If a Subscriber has a child through birth, the child will become a covered Dependent from the moment of birth until sixty (60) days from the date of birth. Notice must be provided to Sanford Health Plan for coverage to continue. Coverage must be applied for the child and any required Premium payment must be made within sixty (60) calendar days from the date of birth.
   Dependent coverage is available for the Subscriber's Spouse, if the Spouse is otherwise eligible for coverage, and/or any other Eligible Dependents, provided all required Premiums are paid and coverage for any new Members is applied for within sixty (60) calendar days of the new child's birth.
   For Subscribers who bought coverage directly through the Federal Marketplace:
   a. You must report the birth of the child to both Sanford Health Plan and the Federal Marketplace. You may report changes to the Federal Marketplace by logging in to your account at www.healthcare.gov or by calling the Federal Marketplace Call Center at (800) 318-2596 *(toll-free)* | TTY/TDD: (855) 889-4325.
   b. Sanford Health Plan must receive payment for the additional Premium, if any, within thirty (30) calendar days from the date we receive the new Dependent's enrollment transaction from the Federal Marketplace.
4. **Adoption, Children Placed for Adoption and Children Subject to a Legal Guardianship Order**
   If a Subscriber adopts a child, has a child placed with him or her as a Dependent or is appointed the legal guardian of a child, that child will become covered as a Dependent as of the date specified within a court order or other legal adoption papers until sixty (60) days from date specified within a court order or other legal adoption papers. Notice must be provided to Sanford Health Plan for coverage to continue that Coverage must be applied for the child and any required Premium payment must be made within sixty (60) calendar days of such date. Coverage includes any necessary care and treatment of medical conditions existing prior to the date specified within the court order or other legal adoption papers that granted initial eligibility. Dependent coverage is available for the Subscriber's Spouse, if the Spouse is otherwise eligible for coverage, and/or any other Eligible Dependents, provided all required Premiums are paid and coverage for any new Members is applied for within sixty (60) calendar days from the date specified within the court order or other legal adoption papers that granted initial eligibility.
   For Subscribers who bought coverage directly through the Federal Marketplace:
   a. You must report the birth of the child to both Sanford Health Plan and the Federal Marketplace. You may report changes to the Federal Marketplace by logging in to your account at www.healthcare.gov or by calling the Federal Marketplace Call Center at (800) 318-2596 *(toll-free)* | TTY/TDD: (855) 889-4325.
   b. Sanford Health Plan must receive payment for the additional Premium, if any, within thirty (30) calendar days from the date we receive the new Dependent's enrollment transaction from the Federal Marketplace.
5. **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 may become covered provided that coverage is applied for and any required Premium payment is made within sixty (60) calendar days of the marriage. The effective date of coverage under the Certificate of Coverage will be the first day of the month following Sanford Health Plan's receipt of the request for enrollment.
   If the Spouse and/or Dependent Children are not added to this Contract within sixty (60) calendar days of the date of marriage, any individuals not already covered by the Contract must wait until the next annual Open Enrollment Period to be eligible to enroll in coverage.
   For Subscribers who bought coverage directly through the Federal Marketplace:
   a. You must report the marriage to both Sanford Health Plan and the Federal Marketplace. You may report changes to the Federal Marketplace by logging in to your account at www.healthcare.gov or by calling the Call Center at (800) 318-2596 *(toll-free)* |TTY/TDD: (855) 889-4325.
   b. Sanford Health Plan must receive payment for the additional Premium, if any, within thirty (30) calendar days from the date we receive the new Dependent's enrollment transaction from the Federal Marketplace.
   c. The effective date of coverage under the Certificate of Coverage will be the first day of the month after we receive the new Dependent's enrollment transaction from the Federal Marketplace.

NOTE: Per federal laws, guidance, and regulations, the sexual orientation and sex/gender of Spouses, married in a jurisdiction with legal authority to authorize their marriage, is not a factor in the issuance of coverage or benefit determinations. Sanford Health Plan, in compliance with federal guidance for all insurance carriers in all states, offers coverage to all legally married Spouses, and any Eligible Dependents as a result of marriage, regardless of the jurisdiction in which the marriage occurred.

Special Enrollment Rights & Qualifying Life Events

A Special Enrollment Period is an enrollment period that occurs outside of the Open Enrollment Period during which time Eligible Dependents who experience a Qualifying Life Event may enroll in coverage under this Contract. The following Qualifying Life Events entitle Eligible Dependents to a Special Enrollment Period:

1. Loss of Minimum Essential Coverage, including exhaustion of COBRA coverage.
2. Gaining or becoming a Dependent through marriage, birth, adoption or placement for adoption, placement in foster care, or through a child support order or other court order, such as appointment as a legal guardian of a child.
3. Enrollment or eligibility error made by the Federal Marketplace or an entity providing enrollment assistance or conducting enrollment activities.
4. Divorce or legal separation.
5. Loss of Dependent status (for example, "aging off" a parent's plan when the child turns twenty-six (26)).
6. Moving to another state or within a state if you move outside of the Service Area.
7. Denial of eligibility for Medicaid or the Children's Health Insurance Program after the Open Enrollment Period has ended.

For coverage purchased through the Federal Marketplace, the following Qualifying Life Events entitle eligible individuals to a Special Enrollment Period, in addition to the Qualifying Life Events listed above:

1. Becoming eligible to enroll in coverage through the Federal Marketplace after gaining status as a U.S. citizen, national, or lawfully present individual or after release from incarceration;
2. Increases or decreases in income enough to change your eligibility for premium tax credits and/or Cost Sharing reductions;
3. Gaining or maintaining status as an Indian or a Dependent of an Indian, as defined by Section 4 of the Indian Health Care Improvement Act, and such individual has not already enrolled or changed enrollment in the month the individual seeks enrollment under this Contract; and
4. Demonstration that a material error related to plan benefits, service area, or Premium influenced the individual's decision to purchase coverage through the Federal Marketplace or that the individual meets other exceptional circumstances as the Federal Marketplace may provide.

NOTE: *Pregnancy alone does not trigger a Special Enrollment Period.*

* *Voluntarily terminating/dropping COBRA coverage before it runs out outside the Open Enrollment Period, does not qualify for a Special Enrollment Period. COBRA coverage must be exhausted (usually eighteen (18) or thirty-six (36) months) or another Qualifying Life Event must occur before an Eligible Dependent is eligible for a Special Enrollment Period.*

** *Loss of Minimum Essential Coverage due to failure to make Premium payment and/or an allowable rescission of coverage does not qualify for a Special Enrollment Period.*

When you experience a Qualifying Life Event, your Special Enrollment Period begins on the date of the Qualifying Life Event and continues for sixty (60) calendar days. For some Qualifying Life Events (such as: the loss of Minimum Essential Coverage; a change in permanent residence; becoming eligible for coverage through the Federal Marketplace after becoming a U.S. citizen, national, or lawfully present individual, or after release from incarceration; and becoming eligible for advance payments of premium tax credits in certain instances) the Special Enrollment Period begins sixty (60) calendar days prior to the date of the Qualifying Life Event and continues until sixty (60) calendar days after the date of the Qualifying Life Event. When coverage becomes effective through a Special Enrollment Period will depend on the date the request for a Special Enrollment Period is received and all required Premiums are paid. Coverage will not be effective prior to the date of the Qualifying Life Event.

For Subscribers who bought coverage through the Federal Marketplace:

1. You must report Qualifying Life Events to both Sanford Health Plan and the Federal Marketplace. You may report changes to the Federal Marketplace by logging in to your account at www.healthcare.gov or by calling the Federal Marketplace Call Center at (800) 318-2596 *(toll-free)* | TTY/TDD: (855) 889-4325.
2. Sanford Health Plan must receive payment for the additional Premium, if any, within thirty (30) calendar days from the date we receive the new Spouse or Dependent Child's enrollment transaction from the Federal Marketplace.

Section 2. How Coverage Ends

Termination of Coverage

Sanford Health Plan may terminate this Contract or coverage of a Member for the following reasons. The Subscriber will be responsible for any Premiums through the date of termination. Unless specifically stated otherwise, coverage ends on the last day of the month in which any of the following events occur (termination will occur at 12:01 a.m., Central Time, the day following the end of coverage).

1. **Failure to Pay Premium**. The Subscriber fails to pay Premium by the end of the grace period.
2. **Written Request for Termination.** The Subscriber or the Federal Marketplace, as applicable, gives us written notice of termination not less than thirty (30) calendar days in advance. We will refund any Premium you have prepaid following the month of termination.
3. **Enrollment in Another Health Plan.** A Member enrolls in other health insurance coverage during an Open Enrollment Period or a Special Enrollment Period.
4. **Product Discontinuance**. We decide to terminate a particular product. We will give written notice to you ninety (90) calendar days prior to termination, and you will have the option to purchase any other health insurance coverage currently being offered by us to individuals with no additional underwriting.
5. **Loss of Eligibility**. A Member is no longer eligible for coverage under this Contract. See *Eligibility Requirements* in Section 1.
6. **Fraudulent Information or Use of ID card by Another**. A Member uses this Certificate of Coverage fraudulently or fraudulently misrepresents or conceals material facts in the application. If this happens, we will recover from the Subscriber any claim payments we made, minus any Premiums paid. Coverage may be rescinded or terminated retroactively to the effective date of coverage. The date identified on the notice of termination is the date coverage will terminate.
7. **Change in Residency or Move Out of the Service Area**. The Subscriber establishes legal residency outside of North Dakota or outside the Service Area.
8. **Discontinuance of All Coverage.** Sanford Health Plan discontinues offering all coverage in the individual market or in all markets in North Dakota provided that: (a) Sanford Health Plan provides all Subscribers and the North Dakota Department of Insurance with written notice of the discontinuance at least one-hundred-eighty (180) calendar days prior to the date the coverage will be discontinued; and (b) all coverage issued or delivered by Sanford Health Plan in the individual market in North Dakota is discontinued and not renewed. The date identified in the notice of discontinuance is the date coverage will terminate.
9. **As Permitted by Law.** Any other reason permitted by Law.

Uniform Modification of Coverage
Sanford Health Plan may, at the time of renewal and with sixty (60) calendar 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 product.

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, under Sanford Health Plan's policy on Member complaints, or the policy on Appeal procedures for medical review determinations.

Effects of Termination

When coverage is terminated by Sanford Health Plan, unless otherwise specified, we will provide at least fifteen (15) calendar days written notice of such termination.

If this Certificate of Coverage or coverage of a Member is terminated for fraud, intentional misrepresentation, or the concealment of material facts Sanford Health Plan:

1. Will not pay for any services or supplies provided after the date of termination.
2. Will retain legal rights; this includes the right to initiate a civil action based on the fraud, concealment, or intentional misrepresentation.
3. May declare, at our option, the Contract void.
4. Will provide at least thirty (30) calendar days written notice of Sanford Health Plan's determination to rescind or retroactively terminate this Contract or coverage of a Member.

NOTE: Unless otherwise stated in this Certificate of Coverage, coverage ends at 12:01 a.m., Central Time, following the day this Contract is terminated. Termination of coverage for the Subscriber constitutes termination of the Contract and coverage for all Members shall cease.

Changes in Eligibility

Change in Eligibility Status.
If coverage was issued outside the Federal Marketplace, you must notify us of any changes that would make the Member no longer eligible for coverage under this Contract. We must be notified of any such changes as soon as possible, but not later than thirty (30) calendar days from the date of the change in eligibility status. This may include the death of the Subscriber, the divorce of the Subscriber and his/her Souse, or a Dependent Child reaching the limiting age. Notice of a change in eligibility must be provided to us in writing. Such notifications must include all information required to effectuate any necessary changes.

If coverage was issued inside the Federal Marketplace, the Subscriber is required to notify the Federal Marketplace of any changes in a Member's eligibility for coverage through the Marketplace. The Federal Marketplace must be notified of any changes in eligibility as soon as possible, but not later than thirty (30) calendar days from the date of the change.

Failure to Notify.
If you fail to notify us or the Federal Marketplace, as applicable, of persons no longer eligible for coverage under this Contract, we are not obligated to provide services to those persons no longer eligible. Our acceptance of Premium for persons no longer eligible for coverage under this Contract will not obligate us to pay for such services.

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 Contract will be covered in accordance with the terms of this Certificate of Coverage until the Member is discharged from such Hospital or other Facility. The Premium that was in effect prior to termination of this Certificate of Coverage will apply.

Conversion of Coverage

Except as stated below, a Member covered under the Contract is entitled to a conversion contract if the Member is no longer eligible for coverage under the Contract or the Contract terminates. A Member is not entitled to a conversion contract in the following circumstances.

1. The Member's loss of eligibility under the Contract was due to the failure to pay Premium or 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 Contract,
2. The Member is covered by or is eligible for benefits under Medicare.
3. The Member is covered by or is eligible for similar Hospital, medical or surgical benefits under applicable Law.
4. 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.
5. 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) calendar days after the Member's loss of eligibility or the date the Contract terminates. The Member shall not be required to meet any additional waiting periods and shall receive credit for any applicable waiting period.

Section 3. How You Get Care

Identification Cards

Sanford Health Plan will send you an identification (ID) card when you enroll. Each covered Member will receive their own Member ID card after enrollment, which should be used when you receive care or fill a prescription. If you fail to show your ID card at the time you receive Health Care Services or prescription drugs, 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, or if you need replacement cards, please contact us or log in to the Member Portal to request a new one at sanfordhealthplan.com/memberlogin.

Conditions for Coverage

Members are entitled to coverage for the Health Care Services (listed in *Covered Services* in Section 4) that are:

1. Medically Necessary and/or Preventive;
2. Received from or provided under the orders or direction of In-Network Participating Practitioner and/or Provider;
3. Approved by Sanford Health Plan, including pre-approval (Certification) where required; and
4. Within the scope of health care benefits covered by this Certificate of Coverage.

However, this specific condition does not apply to Emergency Medical Conditions or Urgent Care Situations 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 Medical Condition 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 are strongly encouraged, to select a Primary Care Physician (PCP) and use that PCP to coordinate their Health Care Services.

Members must reside within the North Dakota Counties of Traill, Cass, Oliver, Burleigh, or Morton as a precondition for coverage under this Certificate of Coverage. It is the Member's responsibility to inform 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 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 4 and 5; and
2. Any applicable Copay, Deductible, and Coinsurance amount as stated in the Summary of Benefits and Coverage, and Pharmacy Handbook.

In-Network and Out-of-Network Coverage

There are *two* (2) levels of coverage that are available:

In-Network Coverage; and Out-of-Network Coverage.

NOTE: This Certificate of Coverage does not cover most Out-of-Network services. *For Out-of-Network coverage, please see Section 4(g).*

In-Network Coverage means Covered Services that are received:

1. from an In-Network Participating Practitioner and/or Provider; or
2. from a Participating Practitioner and/or Provider if an In-Network Participating Provider and/or Provider has recommended the referral and Sanford Health Plan has authorized the referral to a Participating Practitioner and/or Provider; or
3. when experiencing an Emergency Medical Condition or in an Urgent Care Situation; or
4. from a Non-Participating Practitioner and/or Provider when the Member does not have appropriate access to an In-Network Participating Practitioner and/or Provider and Sanford Health Plan has authorized the service.

NOTE: Coverage is provided 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. Additionally, if you

choose to go to a Non-Participating or 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 a Participating Provider, such as anesthesiology or radiology, if rendered in a Participating 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.

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 fifty (50) 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 fifty (50) 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 Providers as indicated on the *Member Welcome Letter* attached to the ID 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 fifty (50) miles of a Member's city of legal residence) is available, claims will be processed at the Out-of-Network Benefit Level.

Transplant Services
Transplant services must be performed at designated In-Network Participating *Centers of Excellence*, or Sanford Health Plan approved Facilities; and are not subject to appropriate access standards, as 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.

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 Contract, and benefits requests. All benefit determinations that are adverse will be made by the person assigned to coordinate the 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 the Appeals and Complaints Department 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.

Routine (Non-Urgent) Pre-Service Benefit Requests

All pre-service benefit determination (approval) requests will be determined within fifteen (15) calendar 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.

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 thirty (30) calendar days with the Plan's determination.

Utilization Review Process

Sanford Health Plan's Utilization Management Department is available 8:00 a.m. to 5 :00 p.m. Central Time, Monday through Friday, by calling us at (800) 805-7938 or TTY/TDD: (877) 652-1844 *(toll-free)*. After business hours, you may leave a confidential voicemail for the Utilization Management Department 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 Care 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. All benefit Adverse Determinations will be made by a person assigned to coordinate the benefit, denial and Appeal process.

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 *(toll-free)* | 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 Certificate of Coverage.

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 this Contract will be provided within thirty (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:
1. You may call or write to the Appeals and Complaints Department. We will help you with questions about your coverage and benefits or investigate any Adverse Determination you might have received; or
2. You may file an Appeal if you have received an Adverse Determination. Please see Section 9 for more information on the Appeals process.

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, Dependent, or Participating Provider. For details on the complaint and Appeals process, see Section 9.

NOTE: If an Adverse Determination is regarding coverage for a Mental Health and/or Substance Use Disorder Service, 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.

Prior Approval Review of Services (Certification/Prior Authorization)

NOTE: The Member is ultimately responsible for obtaining pre-approval (also called Preauthorization or Certification) from the Plan for certain services (outlined below), but your Practitioner and/or Provider may

also request approval. Failure to obtain Certification will result in coverage at a Reduced Payment Level or Denial of Services.

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:

1. The Member's medical information, including diagnosis, medical history and the presence of complications and/or comorbidities.
2. Consultation with the treating Practitioner and/or Provider, as appropriate.
3. 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.

Urgent Care Requests

In determining whether a request is "urgent," Sanford Health Plan shall apply the judgment of a Prudent Layperson, as defined in Section 10. A Practitioner, with knowledge of the Member's medical condition, who determines a request to be urgent shall have such a request treated as an Urgent Care Request, as defined in Section 11.

Services that Require Pre-Approval (Preauthorization/Certification)

Service	For more information, reference Section:
Admissions Inpatient (medical, surgical, mental health/substance abuse), inpatient rehabilitation, long term acute care, residential treatment, skill nursing facility, swing bed facility, and rehabilitation center admissions. **NOTE**: Admission before the day of non-emergency surgery will not be approved unless the early admission is determined to be Medically Necessary by the Plan. Coverage for hospital expenses prior to the day of surgery will be denied unless authorized prior to being incurred.	4(a), 4(b), 4(d)
Ambulance Services (air or ground)	4(c)
All Clinical Trials	4(c)
Durable Medical Equipment (DME) Includes but not limited to: Airway clearance device, communication device, cranial molding helmet, hospital or specialty beds, insulin pumps, selected orthotics, phototherapy UVB light devices, pneumatic compression device (external pump), power wheelchairs or scooters, prosthetic limbs.	4 (a)
Home Health and Home IV Therapy Services	4(a), 4 (b)
Implants and Stimulators External bone growth stimulator, cochlear implant (device and procedure), deep brain stimulator, gastric stimulator, spinal cord stimulator (device and procedure), Vagus nerve stimulator; and device insertion, revision, removal and trials.	4(a)
Oncology Services and Treatment All chemotherapy and radiation therapy as part of an oncology treatment plan.	4(a)
Select Outpatient Services and Treatments Includes but is not limited to: Applied Behavior Analysis (ABA), alopecia treatment, botox, brachytherapy, chelation therapy, dental anesthesia, genetic testing, hyperbaric	4(a), 4 (b)

oxygen therapy, medical nutrition, neuromuscular electrical estimation, medically necessary orthodontia, photodynamic therapy, platelet rich plasma (PRP), radiofrequency ablation, varicose vein treatment.	
Outpatient Surgery Includes but not limited to: abdominoplasty or panniculectomy, bariatric surgery, blepharoplasty, breast implant removal, cataract surgery, revision or re-implantation, breast reconstruction, mastectomy, endoscopic sinus surgery, intrathecal pain pump, mammoplasty, orthognatic procedures, rhinoplasty, septoplasty, back surgery, temporomandibular joint (TMJ)	4(a), 4(b), 4(f)
Transplant Services Includes transplant evaluation and all transplants services including artificial pancreas	4(b)
Referrals to Non-Participating Providers by an In-Network Participating Practitioner and/or Provider Certification is required for the purposes of receiving In-Network Coverage only. If Certification is not obtained for referrals to Non-Participating or Out-of-Network Providers, the services will be covered at the Reduced Payment Level. Certification does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to In-Network Participating Practitioner and/or Providers as described above under Appropriate Access.	

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 certification 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.

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 4(e) of this document.

Routine/Standard Pharmacy Pre-Approval Requests
Routine/Standard (non-urgent) pharmacy pre-approval requests will be reviewed within seventy-two (72) hours 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 in alignment with 45 CFR §156.122 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:

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, per 45 CFR §156.122. 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 under 45 CFR §156.130 and when calculating the actuarial value under 45 CFR §156.135.
4. In determining whether to grant an exception, Sanford Health Plan adheres to 45 CFR §156.122(c), with procedures, as outlined above, allowing Members to request and gain access to clinically appropriate drugs not covered under the Plan's Formulary.

Medical Pre-Approval (Certification) Requests

All requests for prior authorization (Certification) are to be made by the Member or Physician's office at least three (3) business days prior to the scheduled admission or requested service, provided that Sanford Health Plan's Utilization Management Department may review a request for a period of up to fifteen (15) calendar days from the date of the request, together with the information supporting the request, have been received.

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 all of the following factors:
1. Member medical information including:
   a. Diagnosis;
   b. medical history; and
   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;
4. For admissions to Facilities, other than acute Hospitals, additional information may include but are not limited to the following:
   a. history of present illness;
   b. Member treatment plan and goals;
   c. prognosis;
   d. staff qualifications; and
   e. twenty-four (24) hour availability of qualified medical staff.

You are ultimately responsible for obtaining Prior Authorization from Utilization Management. Failure to obtain appropriate Prior Authorization for services will result in a denial or payment reduction to the Out-of-Network Benefit Level and you will be responsible for all costs. However, information provided by the Practitioner and/or Provider's office also satisfies this requirement. You are responsible to confirm with the In-Network Participating Practitioner and/or Provider that any required pre-authorization (Certification) has been obtained.

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 seventy-two (72) 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 571103
- 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 below as the denied claim serves as the initial adverse determination.

Ongoing (Concurrent) Preauthorization Requests (Certification) of Health Care Services

Concurrent Review is utilized when determining whether 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. 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 Practitioner). Hospital/Facility days accumulated beyond the 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 Services.

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 has been notified of the determination by Sanford Health Plan with respect to the internal review request made pursuant to Sanford Health Plan's Appeal procedures. Any reduction or termination by Sanford Health Plan during the course of treatment before the end of the period or number treatments shall constitute an Adverse Determination.

Sanford Health Plan will provide electronic or written notification of an authorization (Certification) to the Member or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service within three (3) calendar days after the telephone notification. Sanford Health Plan shall provide written or electronic notification of the Adverse Determination to the Member, or the Member's Authorized Representative, and those Providers involved in the provision of the service sufficiently in advance (but no later than 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 an Appeal request 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. Members will be notified in all other cases.

Urgent Concurrent Reviews Requested At Least Twenty-Four (24) Hours in Advance of an Expiration of Authorization

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 for medical care, including care for behavioral, mental health, and/or substance use disorders, Sanford Health Plan shall make an urgent Concurrent Review determination and notify the Member, or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service by telephone 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 (Certification) to the Member or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service within three (3) calendar days after the oral notification.

Adverse Determinations

Sanford Health Plan shall provide written or electronic notification of the Adverse Determination to the Member or the Member's Authorized Representative and those Providers involved in the provision of the service sufficiently in advance (but no later than three (3) calendar days of the telephone (oral) notification) of the reduction or termination to allow the Member, or the Member's Authorized Representative, to file an Appeal request 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. Members will be notified in all other cases.

Urgent Concurrent Reviews Requested Within Twenty-Four (24) Hours of an Expiring Authorization

If the request to extend urgent Concurrent Review is not made within twenty-four (24) hours of the expiration of the prescribed period of time or number of treatments for medical care, including care for behavioral, mental health, and/or substance use disorders, Sanford Health Plan will treat the request as an urgent Prospective (Pre-service) Review, and make its decision as soon as possible (taking into account the medical exigencies) but no later than twenty-four (24) hours after the request.

For authorizations (Certifications) and denials, Sanford Health Plan will give telephone notification of the decision to Member, or the Member's Authorized Representative, Practitioners and those Providers involved in the provision of the service within twenty-four (24) hours of receipt of the request. Sanford Health Plan will give 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.

Adverse Determinations

If Sanford Health Plan's determination is an Adverse Determination, Sanford Health Plan 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 *Appeal Procedures* in Section 9, *Problem Resolution*, for details.

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 internal rule, 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.
3. Reasons for any denial or reimbursement or payment for services with respect to benefits under the Contract will be provided within thirty (30) business days of a request.
4. 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.
5. 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.
6. If the Adverse Determination is based on Medical Necessity or Experimental or Investigational Services 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.
7. For Mental Health and/or Substance Use Disorder (MH/SUD) Service Adverse Determinations, if information on any Medical Necessity criteria is requested, documents will be provided for both MH/SUD and medical/surgical benefits within thirty (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 Sanford Health Plan, in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).
8. 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 must be included in the letter. If there is insufficient clinical information to reference a specific clinical practice guideline or policy, the letter must state the inability to reference the specific criteria and must describe the information needed to render a decision.
9. A description of the grievance procedures including how to obtain an expedited review if necessary and any time limits applicable to those procedures, the right to submit written comments, documents or other information relevant to the procedure; an explanation of the Appeal process including the right to member representation; how to obtain an Expedited Appeal if necessary and any time limits applicable to those procedures; notification that expedited External Review can occur concurrently with the internal Appeal process for urgent care/ongoing treatment; and the timeframe the Member has to make an Appeal and the amount of time Sanford Health Plan has to decide it (including the different timeframes for Expedited Appeals).
10. If the Adverse Determination is based on Medical Necessity, notification and instructions on how the Practitioner can contact the Physician, or the appropriate Practitioner to discuss the determination.
11. If a determination is adverse, the right to bring a civil action in a court of competent jurisdiction.
12. Your right to contact the North Dakota Insurance Commissioner at any time at:

North Dakota Insurance Department
600 E. Boulevard Ave.
Bismarck, ND 58505-0320

Email: insurance@nd.gov
Consumer hotline: (800) 247-0560 *(toll-free)*
TTY: (800) 366-6888 *(toll-free)*

Section 4. 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 Provider 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 or Out-of-Network Providers are Non-Covered Services unless otherwise indicated in this Contract.

Section 4(a) Medical services & supplies provided by Practitioners/Providers

IMPORTANT

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

- This Certificate of Coverage, including any amendments, along with your application for coverage and the Summary of Benefits and Coverage constitutes the entire Contract for health care benefits.
- Please remember that all benefits are subject to the terms, 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 3, *How You Get Care*, for valuable information about conditions for coverage.
- You or your Practitioner and/or Provider must get prior authorization (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 that Require Prospective Review/Prior Authorization (Certification)* in Section 3)."
- See the Summary of Benefits and Coverage for any applicable Coinsurance, Copay, Deductible or benefit limitation.

IMPORTANT

Benefit Description

Diagnostic and treatment services

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

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)

Not Covered: *Thermograms or thermography*

Telehealth, e-visit, and video visits benefit

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

- Access to services may be done through a smart phone, tablet or computer.
- For Emergency Medical 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-Member encounter from one site to another, using telecommunication technologies. Services may include tele-monitoring of Member status and transmittal of the information to another Physician or Provider.
- **E-visits**: email, online medical evaluations where Providers interact with Members through a secured email portal.
- **Video Visits:** virtual visits where Practitioners or Providers interact with Members using online means; access points may include mobile smart phones; tablets; or computers.

NOTE: Charges for telehealth, e-visit, and video visit services may be subject to Deductible, Coinsurance, or Copay; 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.

Not Covered:

- *A service that would similarly not be charged for in a regular office visit*
- *Appointment scheduling*
- *Clarification of simple instructions*
- *Communication Devices when not a part of a Sanford Health Plan approved program*
- *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*
- *Installation or maintenance of any telecommunication devices or systems*
- *Provider-initiated e-mail*
- *Reminders of scheduled office visits*
- *Requests for a referral*
- *Services for excluded benefits*
- *Services not Medically Necessary*
- *Telephone assessment and management services*
- *Transmission fees*

Preventive care, adults & children

Preventive Care coverage is as follows:

As outlined in the Sanford Health Plan Preventive Health Guidelines, the following Preventive services, as defined in the Affordable Care Act, received from an In-Network Participating Practitioner and/or Provider are covered without payment of any Deductible, Copay, or Coinsurance requirement that would otherwise apply:

- 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.
- 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;
- With respect to Members 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
- With respect to Members who are women, evidence-informed preventive care and screenings s provided for in the 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)*.

Not Covered:

- *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)*
- *Virtual colonoscopies*

Maternity care

Maternity coverage is as follows:

NOTE: Due to the inability to predict admission; you or your Practitioner and/or Provider are encouraged to notify Sanford Health Plan 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.

Inpatient care is covered for forty-eight (48) hours for a mother and newborn child following a normal vaginal delivery, and inpatient care is covered for ninety-six (96) hours following a caesarean section, without requiring In-Network Participating Practitioner and/or Provider or other Providers to obtain authorization to care for a mother and her newborn child in the inpatient setting for this period of time. However, to use certain Providers or Facilities, or to reduce out-of-pocket costs, Certification may be required. Inpatient care in excess of forty-eight (48) hours following a vaginal delivery and ninety-six (96) hours following a caesarean section is covered if the stay is determined to be reasonable and Medically Necessary.

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)
- Blood type- Limit of One (1)
- Complete blood count (CBC) - Limit of Two (2)
- Depression screening- Limit of One (1)
- Genetic counseling or testing; *Prior authorization is required;*
- Group B streptococci (GBS) - Limit of One (1)
- Hepatitis B screening; -Limit of One (1)
- Hepatitis C Screening - Limit of One (1)
- Human immunodeficiency virus (HIV, during pregnancy) - Limit of One (1)
- Office visits related to a confirmed pregnancy while member is pregnant
- Preeclampsia prevention.
- Rh (Rhesus) incompatibility screening: first pregnancy visit and twenty four (24) to twenty-eight (28) weeks gestation;
- Rubella Screening - Limit of One (1)
- 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)
    a. For additional gestational diabetes benefits, see *Diabetes supplies, equipment and education* later in this Section.
- Screening for sexually transmitted infections (STIs, during pregnancy) - Limit of One (1)
- Tuberculosis (TB) - Limit of One (1)
- Ultrasound (2D) - Limit of Two (2)
- Urine culture- Limit of One (1)
- Urine dipstick or Urinalysis- Limit of Nine (9)

Newborns' 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.

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 durable medical equipment Provider. This does NOT include drugstores or department stores.

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

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.

Not Covered:

- *Amniocentesis or chorionic villi sampling (CVS) solely for sex determination Any expenses related to surrogate pregnancies and/or parenting, except if Surrogate is a covered Member under this Certificate of Coverage and seeking otherwise Covered Services*
- *Any expenses related to surrogate pregnancies and/or parenting, except if Surrogate is a covered Member under this Certificate of Coverage and seeking otherwise Covered Services*
- *Elective abortion services, except in cases of rape, incest, or when mother's life is endangered. Prior Authorization/certification required.*
- *Home birth settings, related equipment and fees*
- *Maternity classes and/or education programs*
- *Non-licensed birthing assistance, such as doulas*

Newborn care

Newborn coverage is as follows:

A newborn is eligible to be covered from birth. For more information, see *When Dependent Coverage Begins* in Section 1, *Enrollment* in this Certificate of Coverage.

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 this section for coverage information of surgery to correct congenital defects).

NOTE: You or your Physician must get Certification of neonatal intensive care nursery services. Failure to get Certification will result in a reduction or denial of benefits. (See *Services that Require Prospective Review/Prior Authorization (Certification)* in Section 3.)

Not Covered: *Newborn delivery and nursery charges for adopted Dependents prior to the date specified within the court order or other legal adoption papers that granted initial eligibility*

Family planning benefits

Family planning coverage is as follows:

- Consultations, and pre-pregnancy planning.
- Member education and counseling, as prescribed by a health care provider for women with reproductive capacity.
- Voluntary Sterilizations, including tubal ligations and vasectomies. *Applicable cost sharing may apply; see contraceptive coverage covered without cost-sharing below.*
- Folic acid supplements are covered at 100% (no cost) for women planning to become pregnant or in their childbearing years.
- 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.
    a. 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
            - Implantable rod.
            - IUD Copper
            - IUD Progestin
        iv. Shot/Injection: includes injectable medroxyprogesterone acetate
        v. Cervical Cap.
    b. 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
    c. 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).

Not Covered:

- *Any expenses related to surrogate parenting except if Surrogate is a covered Member under this Certificate of Coverage and seeking*

otherwise Covered Services

- *Elective abortion services, except in cases of rape, incest, or when mother's life is endangered. Prior Authorization/certification required.*
- *Male Condoms*
- *Reproductive Health Care Services prohibited by the laws of this State*
- *Reversal of voluntary sterilization*

Infertility benefits

Infertility benefits coverage is as follows:

- Testing for the diagnosis of infertility. Coverage for testing includes, but is not limited to:
  - Transvaginal ultrasound for structural evaluation (limit of one (1) per calendar year)
  - Sonogram (limit of one (1) per calendar year)
  - Screenings for stimulations of ovarian reserves and ovarian functions(limit of one (1) per screening per calendar year)
  - Screenings for assessment of polycystic ovarian syndrome (PCOS) (limit of one (1) per calendar year)
  - Semen Analysis (limit of two (2) per calendar year)
  -

**Coverage is subject to Sanford Health Plan Guidelines*

Not Covered:

- *Any expenses related to surrogate parenting or surrogate pregnancies, except if Surrogate is a covered Member under this Certificate of Coverage and seeking otherwise Covered Services*
- *Any other services or supplies related to artificial means of conception*
- *Cryogenic or other preservation techniques used in such or similar procedures*
- *Infertility medication*
- *Reversals of prior sterilization procedures*
- *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*

Allergy care

Allergy care coverage is as follows:

- Testing and treatment
- Allergy injections
- Allergy serum

Not Covered:

- *Air conditions, air filters, or other products to eradicate dust mites*
- *Any form of allergy testing and immunotherapy that is considered experimental or not FDA approved*
- *Chiropractic manipulations for allergies*
- *Diet therapy (specialty foods) for allergies*
- *Duplicate services, including allergy testing for percutaneous scratch tests, intradermal tests, and patch tests Homeopathic treatment of allergies*
- *Provocative food testing*
- *Sublingual allergy desensitization*

Tobacco cessation treatment

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 participants 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 all Food and Drug Administration (FDA)-approved Tobacco cessation medications (including both prescription and over-the-counter medications) for a ninety (90) day treatment regimen when prescribed by a Provider without prior authorization.

Not Covered:

- *Acupuncture*
- *Hypnotism*

Diabetes supplies, equipment, and education

Diabetic Services coverage is as follows:

NOTE: Indicated Durable Medical Equipment (DME) requires Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 3.)

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 • Syringes • Urine testing strips	Pharmacy (prescription required)	Pharmacy Benefit Depending on plan, copay or deductible/coinsurance may apply
• Blood glucose monitors, including Continuous Glucose Monitors (CGM) • Continuous Glucose Monitor Supplies* • 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 Supplies	Durable Medical Provider	Medical Benefit Deductible/Coinsurance will apply

- Routine foot care, including toenail trimming is covered.
- Diabetes self-management training and education shall only be covered if:
    - 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
    - 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 North Dakota Department on Health.

Not Covered: *Food items for medical nutrition therapy*

Dialysis benefit

Dialysis for renal disease coverage is as follows:

- Services include equipment, training, and medical supplies required for effective dialysis care. Coordination of Benefit (COB) Provisions apply. For more information on COB, please see Section 7.

Not Covered:

- *Compact (portable) travel hemodialyzer system*
- *Dialysis services received by Non-Participating Providers when traveling out of the service area*
- *Hemodialysis machine (not separately payable)*

- *Unspecified complication of kidney transplant*
- *Wearable artificial kidney, each*

Phenylketonuria (PKU) benefit

Phenylketonuria Coverage is as follows:

- Testing, diagnosis and treatment of phenylketonuria (PKU) and inherited metabolic diseases of amino acid or organic acid including dietary management, medical foods and low-protein modified food products determined by a Physician to be Medically Necessary, formulas, Case Management, intake and screening, assessment, comprehensive care planning and service referral.

Not Covered:

- *PKU dietary desserts and snack items*
- *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*

Amino acid-based elemental oral formulas benefit

Amino acid-based elemental oral formula coverage is as follows:

- Coverage for medical foods and low-protein modified food products determined by a Physician to be Medically Necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.

Not Covered:

- *Dietary desserts and snack items*
- *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*

Nutritional Counseling

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

Not covered:

- *Dietary surveillance and counseling*
- *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)*
- *Online assessment and management service provided by a qualified no physician health care professional, internet or electronic communications.*

Artificial Nutrition

Artificial Nutrition coverage is as follows:

NOTE: This requires Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 3.)

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

**Coverage is subject to Sanford Health Plan Guidelines.*

Not covered:

Formula and supplements available Over the Counter

Physical, speech and occupational therapies benefit

Therapies coverage is as follows:

- 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. 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; and
    - Speech Therapy -limited to thirty (30) visits per therapy (condition) per Calendar Year
- Coverage is provided for habilitative services that include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. See *Durable Medical Equipment (DME)* later in this section for coverage of devices related to habilitative services. Limited to thirty (30) visits per therapy (condition) per Calendar Year.
- 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.
- 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.

Not Covered:
- *Educational or non-medical services for learning disabilities and/or behavioral problems, including those educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)*
- *Hot/cold pack therapy including polar ice therapy and water circulating devices*
- *Maintenance Care that is typically long-term, by definition not therapeutically necessary but is provided at regular intervals to promote health and enhance the quality of life; this includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or initiated by Members without symptoms in order to promote health and to prevent further problems*
- *Services provided in the Member's home for convenience*
- *Traction services*

Cardiac Rehabilitation Therapy

Cardiac rehabilitation therapy coverage is as follows:
- 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 thirty-six (36) visits per calendar year)

Not covered: *Maintenance Therapy*

Foot care benefits

Foot care coverage is available for the following:
- Routine foot care covered for Members with diabetes only. See *Diabetes supplies, equipment, and education* in this section for more information on Sanford Health Plan policies.
- Non-routine diagnostic testing and treatment of the foot due to illness or injury

NOTE: See *Orthotic and prosthetic devices* in this section for information on podiatric shoe inserts

Not Covered:
- *Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized corrective surgery (unless listed as covered in this Certificate of Coverage)*
- *Diagnosis and treatment of weak, strained, or flat feet*

Hearing services (testing, treatment, and supplies) benefit

Hearing services coverage is as follows:
NOTE: Indicated Durable Medical Equipment (DME) and Implant/Stimulators require Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 3)
- Sudden sensorineural hearing loss (SSNHL), and diagnostic testing and treatment related to acute illness or injury.
- External hearing aids for the treatment of a hearing loss that is not due to the gradual deterioration that occurs with aging and/or other lifestyle factors. *This is a DME that requires Certification.*
    a. Benefit is limited to one hearing aid, per ear, per Member, every three (3) years, in alignment with Medical Necessity and Sanford Health Plan guidelines.
    b. The provision of hearing aids must meet criteria for rehabilitative and/or habilitative services coverage and either:
        i. provide significant improvement to the Member within two (2) months, as certified on a prospective and timely basis by Sanford Health Plan; or
        ii. help maintain or prevent deterioration in physical, cognitive, or behavioral function.
- Cochlear implants and bone-anchored (hearing-aid) implants. *This is an Implant/Stimulator that requires Certification*

Not Covered:
- *All other hearing related supplies, purchases, examinations, testing or fittings*
- *External hearing aids, non-implant devices, or equipment to correct gradual hearing impairment or loss that occurs with aging and/or other lifestyle factors*
- *Tinnitus Maskers*
- *Treatment of gradual deterioration of hearing that occurs with aging and/or other lifestyle factors, and related adult hearing screening*

services, testing and supplies

Vision services (testing, treatment, and supplies) benefit

Vision services coverage is as follows:
NOTE: Indicated Durable Medical Equipment (DME) and Implant/Stimulators require Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 3)

- Non-routine vision exams relating to disease or injury of the eye
- Cataract Surgery. *Certification Required.*
- Dilated eye examination for diabetes-related diagnosis (limit of one exam per Member per year)
- Eyeglasses or contact lenses for Members diagnosed with aphakia (the absence of the lens of the eye, due to surgical removal, a perforated wound or ulcer, or a congenital condition resulting in complications which include the detachment of the vitreous or retina, and glaucoma)
    i. Eyeglasses, including lenses and one frame per lifetime or clear contact lenses for the aphakia eye will be covered for two (2) single lens per Calendar Year
    ii. Scleral Shells: Soft shells limited to two (2) per Calendar Year. Hard shells limited to one (1) per lifetime
- Vision Therapy

Additional pediatric (child) vision services benefit

Coverage is provided for emergency, Preventive and routine vision care for Members up to age nineteen (19). Pediatric vision services will terminate at the end of the month in which the Member reaches age nineteen (19).

PEDIATRIC VISION EXAMS

One examination is allowed annually for routine vision examinations, including:

- Refraction and glaucoma screening (tonometry test);
- Visual training for children under age ten (10);
- Dilated eye examination for diabetes-related diagnosis;
- Visual training services, including orthoptics and pleoptic training, provided to children under age ten (10) for the treatment of amblyopia (commonly referred to as lazy eye).

PRESCRIBED LENSES AND FRAMES

- Coverage for prescribed lenses are allowed once every Calendar Year for prescribed single vision, bifocal or trifocal lenses, including directly related professional services.
- Coverage for frames limited to once every other Calendar Year.
- Coverage for contact lenses in lieu of the prescribed frames and/or lenses benefit once every Calendar Year.

POST-OPERATIVE REFRACTIVE EXAMINATION(S)

- Coverage is provided for a post-operative refractive examination(s) when used instead of the benefits listed above. The annual vision examination, refraction, single vision lenses and frames must be available in order for a post-operative refractive examination(s) benefit to be available. If the Member who is a child uses the vision benefit for a post-operative refractive examination(s), additional benefits for vision examinations and refractions, lenses and frames, or contact lenses will not be allowed until the next Calendar Year.

Not Covered:

- *Additional refractive procedure (including lens) after coverage of initial lens at time of cataract correction*
- *Benefits are not available for complications resulting from refractive surgery*
- *Charges for cosmetic attachments to lenses or frames including but not limited to: monograms or facets, roll or polish edges for rimless lenses, tinting of lenses; i.e. photogray for glass lenses and transition for plastic lenses, slimlite or hi-index lenses, polythin or polycarbonate lenses, oversized lenses; i.e. large or oversize goggle blanks, highpower, specialty lenses; i.e. Smart Seq., executive, bifocal or trifocal extra wide*
- *Contact lens cleaning supplies*
- *Correction of Refractive Errors of the Eye*
- *Lasik eye surgery*
- *Pre- and post-operative refractive services except as specified in the Covered Services Section of this Certificate of Coverage*
- *Protective or scratch coating for plastic lenses*
- *Radial Keratotomy, Myopic Keratomileusis, and any surgery involving corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error*
- *Routine cleaning of Scleral Shells*
- *Safety lenses*
- *Services or supplies determined by Sanford Health Plan to be special or unusual, including orthoptics, vision training and vision aids*

(except for Members under the age of ten (10))
- *Slab-off lenses*
- *Sunglasses*
- *The replacement of lost or broken lenses or frames unless at the time of replacement the Member is eligible for prescribed lenses or frames*
- *Vision exams (routine), vision services and supplies for Members ages nineteen (19) and older, except as specified in the Covered Services Section of this Certificate of Coverage*
- *Vision exams (routine), vision services and supplies for Members ages nineteen (19) and older*
- *Visual field exams*

Orthotic and prosthetic devices benefits

Orthotic and prosthetic device coverage is as follows:

NOTE: Indicated Durable Medical Equipment (DME) requires Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 3.)

- 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.
- 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.
- 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 4(b) for payment information. Insertion of the device is paid under the surgery benefit

Not Covered:
- *Duplicate or similar items*
- *Experimental or Investigational Services or devices not part of an Approved Clinical Trial*
- *Hair transplants or hair plugs*
- *Replacement or repair of items, if the items are damaged or destroyed by the Member's misuse, abuse or carelessness, lost, or stolen*
- *Revision/replacement of prosthetics (except as noted per Sanford Health Plan guidelines (available upon request))*
- *Service call charges, labor charges, charges for repair estimates*

Durable Medical Equipment (DME) benefits

Durable medical equipment (DME) coverage is as follows:

- Coverage is available for DME equipment prescribed by an attending Practitioner and/or Provider that 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 Stanford Health Plan guidelines apply (available upon request).
- Habilitative services, which are Health Care Services and devices that help a person keep, learn, or improve skills and functioning for daily living, are covered. [45 CFR 156.115 (a) (5) (i)]
- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Sanford Health Plan guidelines (available upon request).

NOTE: The following DME 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 3).

- Airway Clearance Device
- Beds such as Hospital beds and mattresses
- Communication Device
- Cranial Molding Helmet
- Equipment that has a cost over $10,000.00
- Insulin Pump
- Phototherapy UVB Light Device
- Pneumatic Compression with external pump
- Prosthetic Limb

- Selected Orthotics

Not Covered:

- *Any other equipment and supplies which Sanford Health Plan determines is not eligible for coverage*
- *Commodes and/or similar convenience items*
- *Coverage is limited to 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.*
- *Deluxe equipment*
- *Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage*
- *Duplicate or similar items*
- *First aid or precautionary equipment such as standby portable oxygen units*
- *Home modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment*
- *Home traction units*
- *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*
- *Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas*
- *Items which are primarily educational in nature or for vocation, comfort, convenience or recreation*
- *Maintenance and service fee for capped-rental items*
- *Orthopedic shoes; custom made orthotics if not covered by Sanford's internal guidelines; over-the-counter orthotics and appliances*
- *Remote control devices as optional accessories*
- *Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness; or are lost or stolen*
- *Revision of durable medical equipment, except when made necessary by normal wear or use*
- *Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates*
- *Self-help and adaptive aids are not a covered benefit, including assistive communication devices and training aids.*
- *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.*
- *Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier*

Implants/Stimulators

Implants/Stimulators coverage is as follows:

- Implants and Stimulators prescribed by an attending Practitioner and/or Provider and are Medically Necessary are covered. Limitations per Certificate of Insurance guidelines apply (available upon request).
- **NOTE:** The following Implants/Stimulators require Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval (Certification) in Section 3.):
- 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

Home health services

Home health services coverage is as follows:

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits (See *Services that Require Prospective Review/Prior Authorization (Certification)* in Section 3).

The following are covered if approved by Sanford Health Plan in lieu of Hospital or Skilled Nursing Facility:

- part-time or intermittent care by a RN or LPN/LVN
- part-time or intermittent home health aide services for direct Member 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 forty (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.

Not Covered:

- *Custodial or convalescent care*
- *Daycare, Attendant, or Homemaker Services*
- *Home delivered meals or laundry services*
- *Nursing care requested by, or for the convenience of the Member or the Member's family (rest cures)*

Private Duty Nursing

Private duty nursing coverage is as follows:

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. (See Services requiring Certification in Section 2.)

Private Duty Nursing is nursing care that is provided to a Member on a one-to-one basis by licensed nurse in an inpatient or home setting when any of the following are true:

- No skilled services are already being provided.
- Skilled nursing resources are available in the facility.
- The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
- The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

Not covered:

- *Services that can be provided safely and effectively by a non-clinically trained person*
- *Services that involve payment of family members or nonprofessional care givers for services performed for the member*

Chiropractic services

Chiropractic services coverage is as follows:

- 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

Not Covered:

- *Hot/cold pack therapy including polar ice therapy and water circulating devices*
- *Therabands, cervical pillows, traction services,*
- *Vitamins and minerals (unless otherwise listed as covered in this Certificate of Coverage),*

Clinical trial benefits

Clinical trial benefits are as follows:

NOTE: This requires Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 3)

Clinical Trials are covered as 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.

1. The Health Care Service that is the subject of the Approved Clinical Trial.
2. 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.
3. 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.
4. An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
5. 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.
6. A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.

7. A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

Not covered:

- *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 as part of the Member's routine care.*
- *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 Approved Clinical Trial; Sanford Health Plan does not cover these costs.*

Oncology treatment benefits

Oncology treatment coverage is as follows:

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. (See Services requiring Certification in Section 3.)

- Radiation Therapy. *This is an Oncology Service/Treatment that requires Certification.*
- Chemotherapy, regardless of whether the Member has separate prescription drug benefit coverage. *This is an Oncology Service/Treatment that requires Certification.*
    - 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

Other treatment therapies not specified elsewhere

Treatment therapy is as follows:

- Inhalation therapy
- Pheresis therapy

Not Covered:

- *Non-surgical treatments that do not meet Sanford Health Plan's Medically Necessary guidelines (available upon request)*
- *Treatment received outside of the United States*

Section 4(b) Services provided by a Hospital or other Facility

IMPORTANT

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

- This Certificate of Coverage, including any amendments, along with your application for coverage and the Summary of Benefits and Coverage constitutes the entire Contract for health care benefits.
- Please remember that all benefits are subject to the terms, definitions, limitations, and exclusions in this Certificate of Coverage 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 Services provided by a Hospital or other Facility are outlined in Section 4(d).
- Be sure to read Section 3, *How You Get Care*, for valuable information about conditions for coverage.
- **YOU MUST GET PRE-AUTHORIZATION (CERTIFICATION) OF SOME OF THESE SERVICES**. See the benefits description below.
- See the Summary of Benefits and Coverage for any applicable Coinsurance, Copay, Deductible or benefit limitation.

IMPORTANT

Benefit Description

Admissions

Admission coverage is as follows:

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (See *Services that Require Prospective Review/Prior Authorization (Certification)* in Section 3.)

Coverage of Hospital Services includes:

- 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 Sanford Health Plan
- The administration of whole blood and blood plasma is a Covered Service. The purchase of whole blood and blood components is not a Covered Service 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 Physician 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 forty-eight (48) hours after the procedure.

Not Covered:

- *Admissions to Hospitals performed only for the convenience of the Member, the Member's family or the Member's Practitioner and/or Provider*
- *Convalescent care*
- *Custodial care*
- *Intermediate Care or Domiciliary Care*
- *Personal comfort items (telephone, television, guest meals and beds)*
- *Rest cures*
- *Services to assist in activities of daily living*
- *Take-home drugs*

Outpatient Hospital or Ambulatory Surgical Center benefits

Outpatient Hospital or Ambulatory Surgical Center Coverage is as follows:

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (See *Services that Require Prospective Review/Prior Authorization (Certification)* in Section 3.)

Health Care Services, furnished in connection with a surgical procedure, performed in an In-Network Participating surgical center, such as:

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

Not Covered:

- *Blood and blood derivatives replaced by the Member*
- *Surgical procedures that can be done at a Physician office setting (i.e. vasectomy, toe nail removal)*
- *Take-home drugs*

Skilled Nursing Facility benefits

Skilled Nursing Facility coverage is as follows:

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (See *Services that Require Prospective Review/Prior Authorization (Certification)* in Section 3.)

- Skilled Nursing Facility Services are covered if approved by Sanford Health 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) calendar 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 (30) mile radius of the Hospital.

Not Covered:

- *Custodial care*
- *Convalescent care*
- *Intermediate Care or Domiciliary Care*
- *Residential care*
- *Rest cures*
- *Services to assist in activities of daily living*

Hospice care benefits

Hospice Care coverage is as follows:

A Member may elect to receive hospice care, instead of the traditional Covered Services provided under the Contract, when the following circumstances apply:

1. The Member has been diagnosed with a terminal disease and a life expectancy of six (6) months or less;
2. 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
3. The Member continues to meet the terminally ill prognosis as reviewed by Sanford Health Plan's Chief Medical Officer over the course of 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
- In-home hospice care per Sanford Health Plan guidelines (available upon request)
- 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 4(a)
- 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 this Section 4(a), but only where the hospice retains responsibility for the care of the Member

Not Covered:

- *Fees for room and board unless Prior Authorized*
- *Independent nursing, homemaker services, respite care*

Reconstructive surgery benefits

Reconstructive surgery coverage is as follows:

NOTE: The following services are considered Outpatient Surgery and 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 3.)

- Surgery to restore bodily function or correct a deformity caused by illness or injury
- 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 Section 4(a)). Deductible, Copays, and Coinsurance apply as outlined in your *Summary of Benefits and Coverage*.

Not Covered:

- *Cosmetic services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services*
- *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 criteria.*

Oral and maxillofacial surgery benefits

Oral and maxillofacial surgery coverage is as follows:

NOTE: Indicated services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 3.)

- 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 twelve (12) months of the occurrence
- Orthognathic Surgery per 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.
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service that requires Certification.*
    - is a child age nine (9) or older - *(Certification is not needed for Members under age nine (9))*; or
    - is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician*;* or
    - has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk

NOTE: For more information on dental benefits, see Section 4(f).

Not Covered:

- *Routine dental care and treatment*
- *Osseointegrated implant surgery (dental implants)*
- *Removal of wisdom teeth*
- *Natural Teeth replacements including crowns, bridges, braces or implants*
- *Hospitalization for extraction of teeth except as required by N.D.C.C. §26.1-36-09.9*
- *Dental x-rays or dental appliances*

- *Shortening of the mandible or maxillae for cosmetic purposes*
- *Services and supplies related to ridge augmentation, implantology, and Preventive vestibuloplasty*
- *Dental appliances of any sort, including but not limited to those related to Sleep Apnea, bridges, braces, appliances, and retainers, except for otherwise specified as covered within this Certificate*

Transplant services

Transplant services coverage is as follows:

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (See *Services that Require Prospective Review/Prior Authorization (Certification)* in Section 3.)

Coverage is provided for transplants according to Sanford Health Plan's 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) calendar 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 Certification)
- Transplant procedure, Facility and professional fees

Transplants that meet the United Network for Organ Sharing (UNOS) criteria and/or Sanford Health Plan policy requirements that are performed at In-Network Participating Practitioner and/or Providers or contracted Centers of Excellence are covered.

Not Covered:

- *Artificial organs, any transplant or transplant services not listed above*
- *Costs related to locating organ donors*
- *Donor expenses for complications that occur after sixty (60) calendar days from the date the organ is removed, regardless if the donor is covered as a Member or not*
- *Expenses incurred by a Member as a donor, unless the recipient is also a Member*
- *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*
- *Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by Sanford Health Plan's Chief Medical Officer or its designee*
- *Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a center of excellence that is a Non-Participating Provider*
- *Storage of stem cells including storing umbilical cord blood of non-diseased persons for possible future use*
- *Transplant evaluations with no end organ complications*
- *Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria*

Anesthesia services

Coverage is available for services of an anesthesiologist, or other certified anesthesia Provider, in connection with a Certified inpatient or outpatient procedure or treatment.

Section 4(c) Emergency services/accidents

IMPORTANT

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

- This Certificate of Coverage, including any amendments, along with your application for coverage and the Summary of Benefits and Coverage constitutes the entire Contract for health care benefits.
- Please remember that all benefits are subject to the terms, 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 3, *How You Get Care*, for valuable information about conditions for coverage.
- See the Summary of Benefits and Coverage for any applicable Coinsurance, Copay, Deductible or benefit limitation.

IMPORTANT

Benefit Description

What is an Emergency Medical Condition?

An **Emergency Medical Condition** is the sudden and unexpected onset of a health condition that would lead a Prudent Layperson acting reasonably and possessing the average knowledge of health and medicine to believe that the absence of immediate medical attention could result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, 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 Medical 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 follow his or her instructions. A Member may always go directly to an urgent care or after-hours clinic.

This Contract covers emergency services necessary to screen and stabilize Members without Certification in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. Network restrictions do not apply to emergency services received from Practitioners and/or Providers outside of the United States.

Emergency care benefits within our Service Area

Services provided for Emergency Medical Conditions and Urgent Care Situations from (i) Non-Participating Practitioners and/or Providers or (ii) Out-of-Network Participating Practitioners and/or Providers will be covered at the same benefit and Cost Sharing level as services provided by an In-Network Participating Practitioner and/or Provider. If Sanford Health Plan determines the condition did not meet prudent layperson definition of an emergency, then the Out-of-Network benefits will apply and the Member is responsible for all costs.

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

The Member or a designated relative or friend must notify Sanford Health Plan and the Member's In-Network Participating Practitioner and/or Provider for primary care services, 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 (i) Non-Participating Practitioners and/or Providers or (ii) Out-of-Network Participating Practitioners and/or Providers, we shall 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 an In-Network Participating Practitioner and/or Provider.

If a Member is admitted to (i) Non-Participating Practitioners and/or Providers or (ii) Out-of-Network Participating Practitioners and/or Providers, then Sanford Health Plan 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 an In-Network Participating Practitioner and/or Provider Hospital.

Emergency care outside our Service Area

If an Emergency occurs when traveling outside of Sanford Health Plan's Service Area, Members should go to the nearest emergency Facility to receive care. The Member or a designated relative or friend must notify Sanford Health 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.

Coverage will be provided for Emergency Conditions outside of the Service Area (at the In-Network benefit level) unless the Member has traveled outside the Service Area for receiving such treatment.

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

NOTE: Unless care is received from In-Network Participating Practitioners and/or Providers, coverage will be at the Out-of-Network benefit level and the Member is responsible for all costs for non-emergency medical care or non-urgent care received when a Member is traveling or studying outside Sanford Health Plan's Service Area.

Ambulance and transportation services

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

1. Medically Necessary; and
2. 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 Sanford Health Plan.

NOTE: Certification is required for all Non-Emergency transportation; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 3.)

Not Covered:

- *Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other Health Care Services*
- *Transfers performed only for the convenience of the Member, the Member's family or the Member's Physician or other Practitioner and/or Provider*
- *Transportation services and/or travel expenses related to a non-Emergency Medical Condition*

Section 4(d) Mental Health and Substance Use Disorder benefits

IMPORTANT

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

- This Certificate of Coverage, including any amendments, along with your application for coverage and the Summary of Benefits and Coverage constitutes the entire Contract for health care benefits.
- Please remember that all benefits are subject to the terms, 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 3, *How You Get Care*, for valuable information about conditions for coverage.
- **YOU MUST GET PRE-AUTHORIZATION (CERTIFICATION) OF SOME OF THESE SERVICES.** See the benefits description below.
- See the Summary of Benefits and Coverage for any applicable Coinsurance, Copay, Deductible or benefit limitation.

IMPORTANT

Benefit Description

Mental health treatment 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 Services 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 Services are not subject to separate Cost Sharing requirements or treatment limitations. Mental Health and Substance Use Disorder Services are covered consistent with generally recognized independent standards of current medical practice, which include the most recent 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 Services are covered with the same Copays, Deductibles, Coinsurance factors, and restrictions as other medical/surgical benefits under the Contract. Coverage for mental health conditions includes:

- Outpatient professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, or other Qualified Mental Health Professionals
- Inpatient Hospitalization
- Medication management
- Diagnostic tests
- Electroconvulsive therapy (ECT)
- Partial Hospitalization Programs
- Intensive Outpatient Programs

NOTE: These benefits are all Admissions or Outpatient Services 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 3.):

- All inpatient services, including those provided by a Hospital or a Residential Treatment Facility

Not Covered:

- *Convalescent care, Domiciliary Care or Maintenance Care*
- *Educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)*
- *Educational services or non-medical services related to learning disabilities or behavioral problems Services related to environmental change*
- *Marriage counseling; pastoral counseling; financial or legal counseling; and custodial care counseling*
- *Milieu therapy*
- *Sensitivity training*

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. (See Services requiring Certification in Section 3):

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.

Substance Use Disorder treatment 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 Services 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 Services are not subject to separate Cost Sharing requirements or treatment limitations. Mental Health and Substance Use Disorder Services are covered consistent with generally recognized independent standards of current medical practice, which include the most recent 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 Services are covered with the same Copays, Deductibles, Coinsurance factors, and restrictions as other medical/surgical benefits under the Contract. Coverage for substance use disorders includes:

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

NOTE: These benefits are all Admissions or Outpatient Services 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 3.):

- All inpatient services, including those provided by a Hospital or a Residential Treatment Facility

Not Covered:

- *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)*
- *Convalescent care, Domiciliary Care or Maintenance Care*
- *Educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)*
- *Educational services or non-medical services related to learning disabilities or behavioral problems*
- *Marriage counseling; pastoral counseling; financial or legal counseling; and custodial care counseling*
- *Milieu therapy*
- *Sensitivity training*
- *Services related to environmental change*

Section 4(e) Prescription drug benefits

IMPORTANT	**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.	IMPORTANT

Benefit Description

- You must fill the prescription at an In-Network Plan Participating Pharmacy. If you choose to go to a Non-Participating or Out-of-Network Pharmacy, you will be responsible for 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 member ID card to the In-Network Pharmacy; if you do not , you will be responsible for all (100%) of the cost(s) 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 changes as they occur. For a copy of the Formulary, contact Pharmacy Management at (855) 305-5062 or TTY/TDD: (877) 652-1844 *(toll-free)* or log in to your Member Portal at www.sanfordhealthplan.com/memberlogin.
- The 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 policy.
- The Plan will utilize Pharmacists Practitioner and/or Providers to review formulary exception requests and promptly grant an exception to the formulary for a Member when prescriber indicates:
  1. the formulary drug(s) causes an adverse reaction in the Member;
  2. the formulary drug(s) is contraindicated for the Member; or
  3. 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 *(toll-free)* | 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 Prior Authorization Requests (Certification) for Prescription Drugs in Section 3 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 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*. 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 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)* 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 manufacturers 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 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)* 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.
- **NOTE:** For Members enrolled in a High Deductible Health Plan, the prescription drug benefit is subject to Deductible and Coinsurance amounts.

Covered Medications and Supplies

To be covered by the Plan, prescriptions must be:

- Prescribed or approved by a licensed physician, physician assistant, nurse practitioner or dentist;
- Listed in the Plan Formulary, unless certification (authorization) is given by the Plan;
- 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.);
- Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

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(a) 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) for non-grandfathered plan.

Not Covered:

- *Any medication that is 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 authorized to prescribe the particular drug*
- *B-12 injection (except for pernicious anemia)*
- *Compound medications containing any combination of the following: Baclofen, Bromfenac, Bupivicaine, Cyclobenzaprine, Gabapentin, Ketamine, Ketoprofen or Orphenadrine*
- *Drug Efficacy Study Implementation ("DESI") drugs*
- *Experimental, Investigational, or Unproven medication for which reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies*
- *Food supplements and baby formula (except to treat PKU or otherwise required to sustain life or amino acid-based elemental oral formulas), nutritional and electrolyte substances*
- *Lifestyle medications used to treat sexual dysfunction, impotence, or sexual inadequacy or to enhance sexual pleasure, intimacy or relationship enhancement; and*
- *Non-FDA approved Medical Cannabis and its equivalents*
- *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)*
- *Medications for cosmetic purposes, including baldness, removal of facial hair, or pigmenting or anti-pigmenting of the skin*
- *Medications not listed in the Plans Formulary,*
- *Medications that are obtained without Prior Authorization or a Formulary exception not approved from the Plan*
- *Medications that may be received without charge under a federal, state, or local program*

- *Medications that provide little or no evidence of therapeutic advantage over other products available.*
- *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;*
- *Medications used to treat infertility*
- *Orthomolecular therapy, including nutrients, vitamins (unless otherwise specified as covered in this Certificate),*
- *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 (*
- *Refills of any prescription older than one year*
- *Repackaged medications*
- *Replacement of a prescription medications due to loss, damage, or theft*
- *Self-administered medications dispensed in a Practitioner or Provider's office or non-retail pharmacy location*
- *Unit dose packaging*
- *Whole Blood and Blood Components Not Classified as medications in the United States Pharmacopoeia*

Section 4(f) Dental benefits

IMPORTANT

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

- This Certificate of Coverage, including any amendments, along with your application for coverage and the Summary of Benefits and Coverage constitutes the entire Contract for health care benefits.
- Please remember that all benefits are subject to the terms, 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 4(b) for inpatient Hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 3, *How You Get Care*, for valuable information about conditions for coverage.
- **YOU MUST GET PRE-AUTHORIZATION (CERTIFICATION) OF THESE SERVICES.** See the benefits description below.
- See the Summary of Benefits and Coverage for any applicable Coinsurance, Copay, Deductible or benefit limitation.

IMPORTANT

Benefit Description

Dental benefit coverage is as follows:

NOTE: The following indicated 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 3.)

- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- 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 twelve (12) 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
- Pediatric Medically Necessary orthodontics. *This Outpatient Service requires Certification.*
- Anesthesia and Hospitalization charges for dental care are covered for a Member who (*This is an Outpatient Service that requires Certification)*:
    - is a child age nine (9) or older- *(Certification is not required for children under nine (9))*; or
    - is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician*;* or
    - has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

Pediatric (child) dental care

Coverage is provided for emergency, Preventive dental care for Members up to age nineteen (19). Pediatric dental services will terminate at the end of the month in which the Member reaches age nineteen (19).

Covered pediatric dental services include:

PEDIATRIC DIAGNOSTIC SERVICES

- Routine oral evaluations allowed twice during Calendar Year.
- Bitewing X-rays allowed once annually except when part of a full mouth survey
- Full mouth survey allowed once every three (3) years
- Panoramic film allowed once every three (3) years
- Intraoral periapical X-rays

PEDIATRIC PREVENTIVE SERVICES
- Prophylaxis allowed four (4) times during a Calendar Year
- Topical fluoride applications allowed twice during a Calendar Year
- Sealants on unfilled, undecayed permanent molars and bicuspids; benefits are limited to a lifetime maximum of two (2) sealants per tooth
- Space maintainers

PEDIATRIC RESTORATIVE SERVICES
- Fillings (pin-retention - limit two (2))
- Inlays, onlays and crowns (not part of a fixed partial denture); replacement of lost or defective inlays, onlays or crowns is allowed once every five (5) years
- Veneers other than cosmetic are allowed once every five (5) years

PEDIATRIC ENDODONTIC SERVICES
- Pulpotomy, pulp capping, root canal therapy, apicoectomy, root amputation, hemisection, bleaching of endodontically treated anterior permanent teeth

PEDIATRIC PERIODONTICS
- Surgical periodontic evaluation once for each course of treatment
- Gingivectomy, gingival curettage, mucogingival surgery, osseous surgery
- Periodontal scaling and root planning

PEDIATRIC PROSTHODONTICS (removable & fixed)
- Dentures (complete and partial); replacement of lost or defective dentures is allowed once every five (5) years
- Tissue conditioning twice per treatment sequence for relining or for new or duplicate dentures
- Relining of immediate dentures once during the year after insertion
- Relining of complete and partial dentures other than in item above, allowed once every three (3) years
- Fixed partial enture; replacement of lost or defective fixed partial dentures is allowed once every five (5) years

PEDIATRIC ORAL AND MAXILLOFACIAL SURGERY
- Simple extractions
- Surgical extractions
- Oral maxillofacial surgery including fracture and dislocation treatment, frenulectomy and cyst and abscess diagnosis and treatment

PEDIATRIC MEDICALLY NECESSARY ORTHODONTICS
- Orthodontic care that is directly related to and an integral part of the medical and surgical correction of a functional impairment resulting from a congenital defect anomaly or required because of injury, accident or illness that damages proper alignment of biting or chewing surfaces of upper and lower teeth

PEDIATRIC ADJUNCTIVE GENERAL SERVICES
- Palliative (emergency) treatment of dental pain
- Anesthesia services
- Occlusal guard for treatment of bruxism allowed once every three (3) years

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Not Covered:
- *Dental care and treatment (routine or non-routine) for Members ages nineteen (19) and older*
- *Dental care for Members under age nineteen (19) for implants, and maxillofacial prosthetics, unless specially covered elsewhere in this Certificate of Coverage*
- *Dental services not specifically listed as a Covered Service by this Certificate of Coverage*
- *Services determined to be cosmetic by Sanford Health Plan*

Section 4(g) Out-of-Network Coverage

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

"Out-of-Network" means services that do not fit the definition of "In-Network" Coverage as set forth in Section 3.

Services considered to be Out-of-Network are those:

a. from Non-Participating Practitioners and/or Providers when Sanford Health Plan has not authorized the referral;
b. from a Participating Practitioner and/or Provider that is not "In-Network" when Sanford Health Plan has not authorized the referral;
c. from a Participating Practitioner and/or Provider outside of the Sanford Health Plan Service Area when the Member is traveling outside of the covered service area for the purpose of receiving such services and:
    i. an In-Network Participating Practitioner and/or Provider has not recommended the referral; and
    ii. 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. Limited and Non-Covered Services

This section describes services that are subject to limitations or **NOT COVERED** under this Contract. Sanford Health Plan is not responsible for payment of Non-Covered Services or excluded benefits.

General Exclusions

1. Alternative treatment therapies including, but not limited to: acupuncture, acupressure, massage therapy (unless covered per Sanford Health Plan guidelines under the Women's Health and Cancer Rights Act for mastectomy/lymphedema treatment), naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, sleep therapy (except for treatment of obstructive apnea), or therapeutic touch
2. 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
3. Any fraudulently Billed Charges or services received under fraudulent circumstances
4. Any services or supplies for the treatment of obesity that do not meet Sanford Health Plan's Medical Necessity 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
5. Autopsies, unless the autopsy is at the request of Sanford Health Plan in order to settle a dispute concerning provision or payment of benefits. The autopsy will be at Sanford Health Plan's expense.
6. Charges for duplicating and obtaining medical records from Non-Participating Providers unless requested by us
7. Charges for professional sign language and foreign language interpreter services unless required by Law
8. Charges for sales tax, mailing, interest and delivery
9. Charges for services determined to be duplicate services
10. Charges for telephone calls to or from a Physician, Hospital or other Practitioner and/or Provider or electronic consultations unless otherwise stated in this Certificate of Coverage
11. Charges that exceed the Maximum Allowed Amount for Non-Participating Providers
12. Complications resulting from a Non-Covered or Denied Service or Procedure
13. Cosmetic services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance or psychological well-being or self-esteem and/or not Medically Necessary, 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
14. Education programs or tutoring services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management
15. Experimental or Investigational Services not part of an Approved Clinical Trial unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies
16. Food items for medical nutrition therapy (except as specifically allowed in as a Covered Service in this Certificate of Coverage)
17. Health Care Services covered by any governmental agency/unit for military service-related injuries/diseases, unless applicable Law requires this Contract to provide primary coverage for the same.
18. 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
19. 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
20. Health Care Services performed by any Practitioner 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 Practitioner in the area. If the immediate family member is the only In-Network Participating Practitioner and/or Provider in the area, the Member may go to a Non-Participating or Out-of-Network Provider and receive In-Network Coverage (Section 3). 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
21. Health Care Services prohibited state or federal rule, law, or regulation
22. Health Care Services provided by a Non-Participating Practitioner and/or Provider or a Participating Practitioner and/or Provider that is not "In-Network" unless there is an emergency or urgent care situation or Prior Authorization/Certification is granted.
23. Health Care Services provided either before the effective date of the Member's coverage or after the Member's coverage is terminated
24. Health Care Services received from a Non-Participating Provider, unless otherwise specified in this Contract
25. 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.
26. Health Care Services that Sanford Health Plan determines are not Medically Necessary
27. Health services received outside of the United States that are not Medically Necessary emergency or urgent care services.
28. 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 Conditions, illness or injury are not the responsibility of the Member.
29. Incidental cholecystectomy performed at the time of weight loss surgery

30. Lifestyle improvement services, such as physical fitness programs, health or weight loss clubs or clinics unless otherwise covered under the Contract
31. Liposuction, gastric balloons, or wiring of the jaw (unless otherwise related to a covered injury or illness)
32. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events. Participating Providers are not permitted to bill Members for services related to such events
33. Removal of skin tags
34. Sequela, which are primarily cosmetic that occur secondary to a weight loss procedure (e.g., panniculectomy, breast reduction or reconstruction)
35. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home, per Sanford Health Plan guidelines
36. 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.
37. 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
38. Services that are not covered Health Care Services
39. Services that are the responsibility of a Third Party Payor or are not billable to health insurance
40. Services to assist in activities of daily living
41. 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.
42. Subsequent surgeries when no tangible evidence of Medical Necessity or improved quality of life exists
43. Therapy and service animals, including those used for emotional or anxiety support
44. Voluntary or involuntary drug testing unless a part of a Plan approved treatment plan

Special situations affecting coverage

Neither Sanford Health Plan, 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:

1. Complete or partial destruction of the Provider's Facilities;
2. Declared or undeclared acts of War or Terrorism;
3. Riot;
4. Civil insurrection;
5. Major disaster or unforeseen natural events which materially interfere with the ability to provide Health Care Services;
6. Disability of a significant portion of the Participating Providers;
7. Epidemic or the inability to obtain vaccines or medicines due to circumstances beyond the control of Sanford Health Plan; or
8. 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.
9. Additionally, non-emergency care may be deferred until after resolution of the above circumstances.

Services covered by other payors

The following are excluded from coverage:

1. Health Care Services for which other coverage is either (1) required by Law to be purchased or provided through other arrangements or (2) has been made available to and was purchased by the Member. Examples include coverage required by workers' 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 workers' compensation. For injuries or sickness which are job, employment or work-related, under which benefits are paid by any workers' compensation or occupational disease act or law, this Certificate of Coverage contains a limitation which states that such Health Care Services are excluded from coverage under this Certificate of Coverage. However, if benefits are paid under the Certificate of Coverage and it is determined that the Member is eligible to receive workers' 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 workers' compensation or occupational disease claim, Member agrees to reimburse Sanford Health Plan the full amount that Sanford Health Plan has paid for Health Care Services when entering into a settlement or compromise agreement relating to compensation for the Health Care Services covered by workers' compensation, or as part of any workers' compensation award. Sanford Health Plan reserves its right to recover against Member even though:
    a. The worker's compensation benefits are in dispute or are made by means of settlement or compromise; or
    b. No final determination is made that the injury or sickness was sustained in the course of or resulted from employment;
    c. The amount of workers' compensation for medical or health care is not agreed upon or defined by Member or the workers' compensation carrier; or
    d. The medical or health care benefits are specifically excluded from the workers' compensation settlement or compromise.

Member will not enter into a compromise or hold harmless agreement relating to any work related claims paid under this Certificate of Coverage, whether or not such claims are disputed by the workers' compensation insurer, without the express written agreement of Sanford Health Plan.

2. 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.
3. Health Care Services for conditions that under the laws of this State must be provided in a governmental institution.

Services and payments that are the responsibility of Member

1. 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 Pharmacy Handbook.
2. The Member is responsible for all Non-Covered Services;
3. Finance charges, late fees, charges for missed appointments and other administrative charges; and
4. Services for which a Member is not legally or as customary practice required to pay, in the absence of a group health plan or other coverage arrangement.

Section 6. How Services are Paid under the Certificate of Coverage

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 Providers and In-Network Facilities, or obtain your prescription drugs at In-Network Pharmacies, you will not have to file claims. You will need to present your ID card and pay your Copay/Coinsurance.

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. In this case, at the time of service the Member's only payment responsibility is to pay the In-Network Participating Practitioner and/or Provider 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 its negotiated contract amounts.

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

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

Reimbursement of Charges by Non-Participating Providers

Sanford Health Plan does not have contractual relationships with Out-of-Network Non-Participating Practitioner and/or Providers. Because of this, this Certificate of Coverage does not cover any costs associated with their services. As Members with no Out-of-Network benefits, any services received Out-of-Network (as defined in Section 4(g)) are the sole responsibility of the Member.

Payment for Air Ambulance Charges

As a safeguard for Members, the reimbursement rate for Out-of-Network air ambulance services is equal to the average of Sanford Health Plan's In-Network rates for air ambulance providers licensed by the North Dakota Department of Health.

A claim made by the Member for Out-of-Network air ambulance services provided by an air ambulance provider licensed by the North Dakota Health Department will be paid in accordance with Sanford Health Plan's above mentioned policy. A payment made in accordance with this policy is the same as an In-Network payment for services.

If you have questions, please call our Customer Service Department.

Healthcare 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.

Time Limits: Claims must be submitted to Sanford Health Plan within one-hundred-eighty (180) calendar 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) day 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

Timeframe for Payment of Claims

The payment for reimbursement of the Member's costs will be made within fifteen (15) calendar days of when the Sanford Health Plan receives a complete written claim with all required supporting information.

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 7. Coordination of Benefits

Sanford Health Plan follows North Dakota Administrative Code 45-08-01.2-03 regarding Coordination of Benefits (COB) rules. The COB provision applies when a person has health care coverage under more than one plan. For purposes of this Section 7, "plan" and "this plan" are defined below. In this section, defined terms specific to this section are not capitalized.

Applicability

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its certificate of coverage terms without regard to the possibility that another plan may cover some expense. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

Definitions (for COB Purposes Only)

1. **A plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.
   a. **Plan includes:** group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental plan, as permitted by Law.
   b. **Plan does not include:** Hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by State law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by Law.

   Each contract for coverage under paragraph 1 above is a separate plan. If a plan has two parts, and COB rules apply only to one of the two, each of the parts is treated as a separate plan.
2. **This plan** means, in a COB provision, the part of this Contract providing the Health Care Services to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of this Contract providing Health Care Services is separate from this plan.

   This Contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
3. **The order of benefit determination rules determine whether this plan is a primary plan or secondary plan when the person has health care coverage under more than one plan.**
   a. When this plan is primary, it determines payment for its benefits first before those of any other plan without considering any other plan's benefits.
   b. When this plan is secondary, it determines its benefits after those of another plan and may reduce the benefits it pays so that no plan benefits exceed 100% of the total allowable expense.
4. **Allowable expense** is a health care expense, including Deductibles, Coinsurance and Copays, that is covered at least in part by any plan covering the person. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the person is not an allowable expense.

   In addition, any expense that a provider by Law or in accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. The following are examples of expenses that are not allowable expenses:
   a. The difference between the cost of a semiprivate Hospital room and a private Hospital room is not an allowable expense, unless one of the plans provides coverage for private Hospital room expenses.
   b. If a person is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an allowable expense.
   c. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an 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 usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the Provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the Provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

e. The amount of any benefit reduction by the primary plan because a covered person has failed to comply with the plan provisions is not an allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred Provider arrangements.

5. **Closed panel plan** is a plan that provides Health Care Services to covered persons primarily in the form of services through a panel of Providers that have contracted with, or are employed by, the plan, and that excludes coverage for services provided by other Providers, except in cases of emergency or referral by a panel member.
6. **Custodial parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the Calendar Year excluding any temporary visitation.

Order of Benefit Determination Rules

When a person is covered by two or more plans, the rules for determining the order of benefits payments are as follows:

1. The primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other plan.
2. (a) Except as provided in 4.b.i below, the plan that does not contain a COB provision that is consistent with N.D. Admin. Code 45-08-01.2, Appendix A is always primary unless the provisions of both plans state that the complying plan is primary.
   (b) Coverage that is obtained by virtue of membership in a group that is 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.
3. A plan may consider the benefits paid or provided by another plan in calculating payment of its benefits only when it is secondary to that other plan.
4. Each plan determines its order of benefits using the first of the following rules that apply:
   a. **Non-Dependent or Dependent.** The plan that covers the person other than as a Dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan and the plan that covers the person as a Dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, 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 (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan.
   b. **Dependent Child covered under more than one plan.** Unless there is a court decree stating otherwise, when a Dependent Child is covered by more than one plan the order of benefits is determined as follows:
      i. For a Dependent Child whose parents are married or are living together, whether or not they have ever been married:
         1) the plan of the parent whose birthday falls earlier in the Calendar Year is the primary plan; or
         2) if both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
      ii. For a Dependent Child whose parents are divorced or separated or not living together, whether or not they have ever been married:
         1) If a court decree states that one of the parents is responsible for the Dependent 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 plan years commencing after the plan is given notice of the court decree;
         2) If a court decree states that both parents are responsible for the Dependent Child's health care expenses or health care coverage, the order of benefits shall be determined as if the parents are married or living together, as set forth above;
         3) If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent Child, the order of benefits shall be determined as if the parents are married or living together, as set forth above; or
         4) If there is no court decree allocating responsibility for the Dependent Child's health care expenses or health care coverage, the order of benefits for the child are as follows:
            a) The plan covering the custodial parent;
            b) The plan covering the spouse of the custodial parent;
            c) The plan covering the non-custodial parent; and then
            d) The plan covering the spouse of the non-custodial parent.
      iii. For a Dependent Child covered under more than one plan of individuals who are not the parents of the child, the provisions of paragraphs 4.a and 4.b above shall determine the order of benefits as if those individuals were the parents of the child.
   c. **Active employee or retired or laid-off employee.** The plan that covers a person who is an active employee, that is, an employee who is neither laid off nor retired, is the primary plan. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule set forth in paragraph 4.a above can determine the order of benefits.

d. **COBRA or State continuation coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by Law is covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree or covering the person as a Dependent of an employee, member, subscriber, or retiree is the primary plan and the COBRA or State or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule set forth in paragraph 4.a above can determine the order of benefits.

e. **Longer or shorter length of coverage.** The plan that covered the person as an employee, member, policyholder, subscriber, or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.

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

Effect of COB on the Benefits of this Plan

When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a Policy Year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, the secondary plan shall credit to its plan Deductible any amounts it would have credited to its Deductible in the absence of other health care coverage.

If a covered person is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by a non-panel Provider, benefits are not payable by one closed panel plan; COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this plan and other plans. Sanford Health Plan may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this plan and other plans covering the person claiming benefits. Sanford Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must give Sanford Health Plan any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another plan may include an amount that should have been paid under this plan. If it does, Sanford Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this plan. Sanford Health 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 the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Sanford Health 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; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Calculation of Benefits, Secondary Plan

f 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 100% 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.

Coordination of Benefits with Governmental Plans

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 Plans (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

Coordination of Benefits with Medicare
This contract is not a Medicare Supplement Policy. Any benefits covered under both this Contract and Medicare will be paid pursuant to Medicare Secondary Payor legislation. As Medicare secondary payor, benefits under this Contract shall be determined after those of Medicare. Where Medicare is the responsible payor, all sums payable by Medicare for services provided to Members shall be reimbursed by or on behalf of the Members to Sanford Health Plan, to the extent Sanford Health Plan has made payment for such services.

Coordination of Benefits with Medicaid
A Member'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 Member. Any such benefit payments will be subject to the State's right to reimbursement for benefits it has paid on behalf of the Member, as required by the 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.

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.

1. 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.
2. TRICARE will pay last; TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim.
3. When a TRICARE beneficiary is covered under this Certificate of Coverage, 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).
4. 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.

Sanford Health Plan does not:

1. Provide financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under this Contract, which would (in the case of such enrollment) be a primary plan (the incentive prohibition); and
2. Deprive a TRICARE-eligible employee of the opportunity to elect to participate in this Contract. is covered by both Medicaid and TRICARE.

Section 8. Subrogation and Right of Reimbursement

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," and this part of the Certificate of Coverage covers such situations.

Sanford Health Plan may give or obtain needed information from another insurer or any other organization or person. Each and every Member hereby authorizes Sanford Health Plan to give or obtain any medical or other personal information reasonably necessary to apply the provisions of Sections 7 and 8.

A Member will give Sanford Health Plan the information it asks for about other plans and their payment of allowable charges. 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" and this part of the Certificate of Coverage covers such situations.

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.

Sanford Health Plan's Rights of Subrogation

In the event of any payments for benefits provided to a Member under this Contract, 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 Maximum Allowed Amount 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 Maximum Allowed Amount 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 Maximum Allowed Amount charged 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 Certificate of Coverage. This includes Sanford Health Plan's right to bring suit against the third party in the Member's name.

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

Erroneous Payments

To the extent payments made by Sanford Health Plan with respect to a Member are in excess of the Maximum Amount Allowed of payment necessary under the terms of this Contract, 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 Sanford Health 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 Member.

Members Responsibilities

1. 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.
2. 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.
3. Any Member who fails to cooperate in Sanford Health Plan's administration of this part shall be responsible for the Maximum Allowed Amount 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 Member if a Member refuses to cooperate with Sanford Health Plan's subrogation and reimbursement rights or refuses to execute and deliver such papers as Sanford Health Plan may require in furtherance of its subrogation and reimbursement rights. Further, in the event the Member 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 Member or his or her authorized legal representative obtains valid court recognition and approval of Sanford Health Plan's 100%, first-dollar subrogation and reimbursement rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.
4. 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 this Certificate of Coverage.

Separation of Funds

Benefits paid by Sanford Health Plan, funds recovered by the Member(s), and funds held in trust over which Sanford Health Plan has an equitable lien exist separately from the property and estate of the Member(s), such that the death of the Member(s), or filing of bankruptcy by the Member(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.

Payment in Error

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

Section 9. Problem Resolution

Member Appeal and Complaint Procedures – OVERVIEW

A Member has the right to contact the Insurance Department for assistance at any time at:

North Dakota Insurance Department
600 E. Boulevard Ave.
Bismarck, ND 58505-0320

Email: insurance@nd.gov
Consumer hotline: (800) 247-0560 *(toll-free)*
TTY: (800) 366-6888 *(toll-free)*

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 Member is entitled to them.

Claims for benefits under this Contract can be post-service, pre-service, or concurrent. This Section 9 explains how you can file a complaint regarding services provided by Sanford Health Plan; or Appeal a partial or complete denial of a claim.

For information on Formulary exception requests, see Section 3, *Prospective (Prior Authorization/Certification) 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 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.

Spanish (Español): Para obtener asistencia en Español, llame al (800) 892-0675 *(toll-free)*.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 892-0675 *(toll-free)*.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 892-0675 *(toll-free)*.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 892-0675 *(toll-free)*.

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 *(toll-free)*.

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 *(toll-free)*; 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 9.

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

Maximum Appeal Timelines

Type of Notice	Emergency	Pre-Service	Post-Service
Initial Determinations	72 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

Definitions

Adverse Determination: Means 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) that is based on:

1. A determination of an individual's eligibility to participate in this Contract;
2. A determination that a benefit is not a Covered Service;
3. The imposition of a source-of-injury exclusion, network exclusion, application of any Utilization Review, or other limitation on otherwise Covered Services;
4. A determination that a benefit is an Experimental or Investigational Service 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 Certificate of Coverage and deny claims.

Appeal: Means a request to change a previous Adverse Determination made by Sanford Health Plan.

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.

Inquiry: A telephone call regarding eligibility, Contract interpretation, Sanford Health Plan policies and procedures, or plan benefit 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.

Urgent Care Situation: A degree of illness or injury that is less severe than an Emergency Medical Condition, but requires prompt medical attention within twenty-four (24) hours. An Urgent Care Request means a request for a HealthCare Service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination could:

1. 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 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 10. A Practitioner, with knowledge of the Member's medical condition, who determines a request to be "urgent", shall have such a request treated as an Urgent Care Request by Sanford Health Plan.

Complaint (Grievance) Procedures

A Member has the right to file a Complaint either orally or in writing with 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 may be reached toll-free at (877) 652-8544 | TTY/TDD: (877) 652-1844 *(toll-free)*, 8:00 a.m. to 5:00 p.m., Central Time, Monday through Friday.

To contact the Appeals and Complaints Department and file a Complaint in a language other than English, call (800) 892-0625 *(toll-free)*. Language assistance services are free of charge. To complain in writing, send to the Appeals and Complaints Department at the address below or use the secure communications portal of your MySanfordHealthPlan account at www.sanfordhealthplan.com/memberlogin.

Oral Complaints
A complainant may orally submit a Complaint to Customer Service. If the Complaint is not resolved to the Complainant's satisfaction within ten (10) business days of Sanford Health Plan receiving the oral Complaint, and the Complainant wants Sanford Health Plan to take further action, the Complainant must submit a Complaint in writing to Sanford Health Plan. The Appeals and Complaints Department will notify the Complainant of the requirement for a written Complaint if the Complainant wants to receive Sanford Health Plan investigation findings. Upon request, Customer Service will provide assistance in submitting Complaint information free of charge.

Written Complaints
A Complainant can seek further review of an oral Complaint not resolved by phone by submitting a written Complaint. A Member, or his/her Authorized Representative, must send the written Complaint, the reasons they believe they are entitled to benefits, and any supporting documentation, to:

Sanford Health Plan
Appeals and Complaints Department
PO Box 91110
Sioux Falls, SD 57109-1110
or Fax: (605) 312-8910

Complaints based on discrimination must be sent to the attention of our Civil Rights Coordinator.

A written Complaint may also be submitted through the secure communications portal of a Member's online account at www.sanfordhealthplan.com/memberlogin.

The Appeals and Complaints Department will notify the Complainant within ten (10) business days of receiving a written Complaint, 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.

Written 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:

1. 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.
2. In certain circumstances, the time period may be extended by up to fourteen (14) calendar days upon agreement. In such cases, Sanford Health Plan will notify the Complainant in advance, of the reasons for the extension.
3. 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 seventy-two (72) hours.

Unresolved Complaints (Grievances)
If a 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 toll-free at (877) 652-8544 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*, 8:00 a.m. to 5:00 p.m., Central Time, Monday through Friday. To contact Sanford Health Plan in a language other than English, call (800) 892-0625 *(toll-free)*. Language assistance services are free of charge. 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 written responses you receive from Sanford Health Plan.

Appeal Procedures

Types of Appeals

1. A **pre-service Appeal** is a request to change an Adverse Determination that Sanford Health Plan denied, in whole or in part, in advance of

the Member obtaining care or services.
2. A **post-service Appeal** is a request to change an Adverse Determination for care or services already received by the Member.
3. An **expedited (urgent) Appeal** is a request to change a previous Adverse Determination made by Sanford Health Plan when services subject to the request are of an urgent or emergent nature.

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.

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 must be called the "authorization number."

Internal Appeal of Adverse Determination (Denial)

Filing Deadline

Appeals must be made within one-hundred-eighty (180) calendar days from Member notification of an Adverse Determination.

Within one-hundred-eighty (180) calendar days after the date of receipt of a notice of an Adverse Determination sent to a Member, or the Member's Authorized Representative, the Member, or Authorized Representative, may file an Appeal with Sanford Health Plan requesting a review of the Adverse Determination. To ease in the process of filing an Appeal, Members may use Sanford Health Plan's *Appeal Filing Form,* which is attached to all Sanford Health Plan Explanation of Benefits (EOB); the form may also be found by logging in to your online account at www.sanfordhealthplan.com/memberlogin. To get a paper copy of the form, contact Customer Service.

To Appeal an Adverse Determination

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
ATTN: Appeals
PO Box 91110
Sioux Falls, SD 57109-1110.

You may also Appeal by calling (877) 652-8544 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*; or faxing (605) 312-8910 *(long-distance charges may apply)*.

Written Notification Process for Internal Appeals

The written decision for the Appeal reviews will contain the following information:

1. The specific reason for the Adverse Determination in easily understandable language.
2. Reference to the specific internal plan rule, guideline, or protocol on which the determination was based and notification that the Member will be provided a copy of the actual Sanford Health Plan 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 Certificate of Coverage will be provided within thirty (30) business days of a request. Members shall have the right to review all evidence and present evidence and testimony.
3. If the Adverse Determination is regarding coverage for a Mental Health and/or Substance Use Disorder Service, 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 Sanford Health Plan 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) Service Adverse Determinations, if information on any Medical Necessity criteria is requested, documents will be provided for both MH/SUD and medical/surgical benefits within thirty (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 Sanford Health 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 must be included in the letter. If there is insufficient clinical information to reference a specific clinical practice guideline or policy, the letter must state the inability to reference the specific criteria and must describe the information needed to render a decision.
8. A description of Sanford Health Plan's Appeal procedures including how to obtain an Expedited Appeal if necessary (and any time limits applicable to those procedures), the right to submit written comments, documents or other information relevant to the Appeal; an explanation of the Appeal process including the right to Member representation; how to obtain an Expedited Appeal if necessary and any time limits applicable to those procedures; notification that expedited external review can occur concurrently with the internal Appeal process for urgent care/ongoing treatment; and the timeframe the Member has to make an Appeal and the amount of time Sanford Health 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 Physician or appropriate Practitioner to discuss the determination.
10. Notice of the Member's right to contact the Insurance Department for assistance at any time at:

    North Dakota Insurance Department
    600 E. Boulevard Ave.
    Bismarck, ND 58505-0320

    Email: insurance@nd.gov
    Consumer hotline: (800) 247-0560 *(toll-free)*
    TTY: (800) 366-6888 *(toll-free)*
11. Notice of the right to initiate the external review process for Adverse Determinations based on Medical Necessity. Refer to *External Independent Review of Final Adverse Determinations (Denial)* in this section for details on this process. Final Adverse Determination letters from Sanford Health Plan 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.
12. If the Adverse Determination is completely overturned, the determination notice must state the decision and the date.

Internal Appeal Rights and Standard (Non-Urgent) Appeal Procedures

If the Member or a Member's Authorized Representative (as designated in writing by the Member) files an Appeal for an Adverse Determination, the following Appeal rights apply:

1. 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.
2. The Member shall be provided, free of charge, any new or additional evidence considered, relied upon, or either 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.
3. 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.
4. Before Sanford Health Plan issues a final Adverse Determination based on any 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.
5. 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.
6. 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.
7. Full and thorough investigation of the substance of the Appeal, including any aspects of clinical care involved, will be coordinated by the department supervisor. Sanford Health Plan will document the substance of the Appeal and any actions taken.
8. 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.
9. The review shall not afford deference to the initial Adverse Determination; and shall be conducted by a named 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.
10. 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 an Experimental or Investigational Service, 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.
11. 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.

12. 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.
13. The attending Practitioner and/or Provider, and the Member, will be made aware of their responsibility for submitting any documentation required for resolution of the Appeal within three (3) business (working) days of Sanford Health Plan's request upon receipt of the Appeal.
14. Sanford Health Plan will provide notice of any Adverse Determination in a manner consistent with applicable federal regulations.
15. If the Appeal determination is adverse, the Member shall be informed of their right to file a civil suit in a court of competent jurisdiction upon completion of Sanford Health Plan's Appeal procedures.
16. If Sanford Health Plan fails to provide adequate notification of a benefit determination, the one-hundred-eighty (180) day limitation to file an Appeal does not apply. If such situation occurs, a Member should file an Appeal as soon as reasonably possible and the right to file a suit in federal court is not bound by the one-hundred-eighty (180) day filing limitation.

Standard (Non-Urgent) Appeal Notification Timelines

For Pre-service Claim (Prospective) Appeals: Sanford Health Plan will notify the Member or their Authorized Representative, and any Practitioner and/or Providers involved in the Appeal of its determination in writing or electronically of Sanford Health Plan's internal Appeal determination within thirty (30) calendar days of receipt of Appeal. For initial determination request timelines, see Section 4, *Utilization Management.*

For Post-service Claim Appeals: Sanford Health Plan will notify the Member or their Authorized Representative, and any Practitioner and/or Providers involved in the Appeal of its determination in writing or electronically of Sanford Health Plan's internal Appeal determination within sixty (60) calendar days of receipt of Appeal. For initial determination request timelines, see Section 3, *Utilization Review Process.*

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.

Expedited (Urgent) Appeal Procedure

The procedures in this section are used for an **Expedited (urgent) Appeal**, which is when the Member's condition is urgent or emergent and an *Urgent Care Request* is being appealed, as defined in Section 10 of this Certificate of Coverage.

An **Expedited (urgent) Appeal** for **pre-service or concurrent** claims are utilized if the Member, or Practitioner and/or Provider acting on behalf of the Member, believes that an Expedited (urgent) Appeal is warranted. As described in this section and in Section 3 (for Benefit and/or Medical Care Determinations), the rights and procedures of a standard internal Appeal apply equally to Expedited (urgent appeals).

For an Expedited (urgent) Appeal, the request for an expedited review may be submitted orally or in writing. Sanford Health Plan also accepts all necessary information for Expedited (urgent) Appeal requests by telephone or electronically. In such situations, the Practitioner who made the initial Adverse Determination may review the Appeal and overturn the previous decision.

Sanford Health Plan will notify the parties involved of its Expedited Appeal determination orally, or in writing, by facsimile or other expedient means. The Member and those Practitioners and/or Providers involved in the Appeal will also receive written notification within three (3) calendar days of the oral notification.

NOTE: If a Member's claim or Appeal is no longer considered or determined to be urgent or emergent, as defined in this Certificate of Coverage, it will be handled according to the standard (non-urgent) Appeal procedures and timelines, depending upon the circumstances.

If the Expedited Appeal 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.

Expedited (Urgent) Appeal Notification Timelines

The determination will be made and provided to the Member, those Practitioners and/or Providers involved in the Expedited Appeal request, via oral notification by Utilization Management, as expeditiously as the Member's medical condition requires, but no later than within seventy-two (72) hours of receipt of the request.

If the information is not received in a timely manner as stated in Section 3, *Utilization Review Process*, notification will occur as expeditiously as the Member's medical condition requires, but no later than forty-eight (48) hours after receipt of all the information necessary to process the request for benefits.

External Independent Review of Final Adverse Determination (Denial)

Sanford Health Plan will follow the procedure for providing independent, external review of final determinations as outlined in the Affordable Care Act. Accordingly, an independent external review is not available for a benefit denial when it does not involve medical judgment.

NOTE: Adverse Determinations, e.g. denials that do not involve medical/clinical review, are not eligible for an external review. Sanford Health Plan's decision on benefit determinations is final and binding.

External Appeal Review Program – OVERVIEW

External Review Requests

Members may file a request for external review with Sanford Health Plan or with the North Dakota Insurance Commissioner at:

North Dakota Insurance Department
600 E. Boulevard Ave.
Bismarck, ND 58505-0320

Email: insurance@nd.gov
Consumer hotline: (800) 247-0560 *(toll-free)*
TTY: (800) 366-6888 *(toll-free)*

An Expedited Appeal procedure is used when the condition is an Urgent Care Situation.

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 Sanford Health 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.

External Appeal Review Program Procedures

External Review Requests

Members may file a request for external review with Sanford Health Plan or with the North Dakota Insurance Commissioner at:

North Dakota Insurance Department
600 E. Boulevard Ave.
Bismarck, ND 58505-0320

Email: insurance@nd.gov
Consumer hotline: (800) 247-0560 (toll-free)
TTY: (800) 366-6888 (toll-free)

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), a determination that treatment is an Experimental or Investigative Service if it is ensured that adequate clinical and scientific protocols are taken into account as part of the external review, or an Adverse Determination involving the cancellation or discontinuation of coverage that has a retroactive effect.
    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 review 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.
    c. The external review organization will communicate its decision in clear terms in writing to the Member and Sanford Health Plan. The decision will include:
        i. a general description of the reason for the request for external review;
        ii. the date the independent review organization received the assignment from Sanford Health Plan to conduct the external review;
        iii. the date the external review was conducted;
        iv. the date of its decision;
        v. the date the external review was conducted;
        vi. the date of its decision;
        vii. the principal reason(s) for the decision, including any, Medical Necessity rationale or evidence-based standards that were a basis for its decision; and
        viii. the list of titles and qualifications, including specialty, of individuals participating in the external 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.
    d. 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.
3. Conduct of the external appeal review program as follows:
    a. 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:
        i. 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 at the time the Health Care Service was provided;
        ii. 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 Sanford Health Plan's requirements for Medical Necessity, appropriateness, health care setting, or level of care or effectiveness;
        iii. The Member has exhausted Sanford Health Plan's internal Appeal process unless the Member is not required to exhaust the Sanford Health Plan's internal Appeal process as defined above; and
        iv. The Member has provided all the information and forms required to process an external review.
    b. 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.
        i. If the request is not complete, Sanford Health Plan 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, Sanford Health Plan 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 Law, such as filing a lawsuit.

ii. 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.
iii. 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.

c. The North Dakota Insurance Department contracts with the independent, external review organization that:
i. is accredited by a nationally recognized private accrediting entity;
ii. 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.
iii. 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.
iv. has no material professional, familial or financial conflict of interest with Sanford Health Plan.

d. 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.
e. 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.
f. 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.
g. 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.
h. 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.

4. 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 3, will comply with applicable Law. Should a conflict exist between Sanford Health Plan procedures and applicable Law, the applicable Law 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.

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 Review 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 North Dakota Insurance Commissioner for assistance at any time at:
   North Dakota Insurance Department
   600 E. Boulevard Ave.
   Bismarck, ND 58505-0320
   Email: insurance@nd.gov
   Consumer hotline: (800) 247-0560 (toll-free)
   TTY: (800) 366-6888 (toll-free)
3. An expedited external review is not provided for Adverse Determinations of Retrospective Review.
4. Immediately upon receipt of the request from the Member or the Member's Representative, the North Dakota Insurance Department (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 Authorized Representative that they may appeal to the State insurance department.
5. 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.
6. 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.
7. 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.
8. At the same time a Member, or the Member's Authorized Representative, files a request for an internal Expedited Appeal 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.
9. 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 10: Definitions of Terms Used in the Certificate of Coverage

Active Course of Treatment	Treatment, including treatment for mental health and substance abuse disorders that satisfies any of the following. 1. An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted; 2. An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits; 3. The second or third trimester of pregnancy, through the postpartum period; or 4. An ongoing course of treatment for a health condition for which a treating health care provider attests that discontinuing care by that health care provider would worsen the condition or interfere with anticipated outcomes.
Adverse Determination	Any of the following determinations: 1. 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 coverage; 2. 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 3. 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: 1. Has an organized staff of Practitioners; 2. Has permanent Facilities that are equipped and operated mostly for performing surgery; 3. Has continuous Practitioner's services and Nursing Services when a Member is in the Facility; and 4. Does not have services for an overnight stay.
Appeal	A Member's request to Sanford Health Plan to change a previous Adverse Determination made by Sanford Health Plan. An Appeal follows the internal Appeal process as outlined in this Certificate of Coverage.
Approved Clinical Trial	A phase I, II, III, or 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: 1. A federally funded or approved trial; 2. A clinical trial conducted under an FDA investigational new drug application; or 3. A drug trial that is exempt from the requirement of an FDA investigational new drug application.
Authorized Representative	A person to whom a covered person 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 the 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.
Billed Charge	The amount a Provider bills for all services and supplies, whether or not the services and supplies are covered under this Certificate of Coverage.
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, and/or other health conditions.
Certification	Certification is a determination by Sanford Health Plan that a prior 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. Also known as Authorization.
Coinsurance	The percentage of charges to be paid by a Member for Covered Services. Coinsurance payments begin once you meet any applicable Deductible.
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 received at a Residential Treatment Facility and ongoing outpatient services, including ongoing ambulatory care.
[This] Contract or [The] Contract	The contract between Sanford Health Plan and the Subscriber including this Certificate of Coverage (including all attachments, amendments and addenda), the enrollment letter, the application(s) submitted by the Subscriber, the Summary of Benefits and Coverage, and the Pharmacy Handbook.
Copay	An amount that a Member must pay in order to receive a Covered Service that is not fully pre-paid.
Cost Sharing	An amount the Member must pay for Covered Services. Cost Sharing can be in the form of Copays, 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: 1. A group health benefit plan (as defined under North Dakota law); 2. A health benefit plan (as defined under North Dakota law); 3. Medicare or Medicaid; 4. Civilian health and medical program for uniformed services; 5. A health plan offered under 5 U.S.C. 89; 6. A medical care program of the Indian Health Service or of a tribal organization; 7. A state health benefits risk pool, including coverage issued under N.D.C.C. Chapter 26.1-08; 8. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government; 9. A health benefit plan under §5(e) of the Peace Corps Act Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e); 10. A church plan; or 11. A state's children's health insurance program funded through Title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].
Deductible	The amount that a Member must pay each Calendar Year before Sanford Health Plan begins to pay the costs or provide benefits for Covered Services. The Deductible is set forth in the Summary of Benefits and Coverage. Copays do not count toward the Deductible.
Dependent	The Subscriber's Spouse and any Dependent Child.
Dependent Child(ren)	To be eligible for coverage, a dependent child must satisfy both (1) and (2) below: 1. 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. 2. Be one of the following: a. under age twenty-six (26); or b. incapable of self-sustaining employment and dependent on his or her parents or other care providers for lifetime care and supervision because of a disabling condition that was present before the child was age twenty-six (26). If Sanford Health Plan so requests, the Subscriber must provide proof of the child's disability within thirty-one (31) calendar days of Sanford Health Plan's request.
Dependent of Dependent Child	To be eligible for coverage, a 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: a. natural child of a Dependent Child; b. child placed with a Dependent Child for adoption; c. child legally adopted by a Dependent Child; d. child for whom a Dependent Child has legal guardianship; e. stepchild of a Dependent Child; or f. foster child of a Dependent Child.
Domiciliary Care	Domiciliary Care consists of a protected situation in a community or Facility, which includes room, board, and personal services for individuals who cannot live independently yet do not require twenty-four (24) hour Facility or nursing care.

Eligible Dependent	Any Dependent who meets the specific eligibility requirements of this Contract.
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, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.
Expedited Appeal	An expedited review involving Urgent Care Requests for Adverse Determinations of Prospective (Pre-service) or Concurrent Reviews must 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: 1. 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 2. 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 Centers or treatment centers, Skilled Nursing Facilities, Residential Treatment Facilities, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings.
Federal Marketplace	The health benefit exchange established by the Affordable Care Act for the state of North Dakota.
Formulary	A list of covered prescription drugs, both generic and brand name, maintained by Sanford Health Plan and applicable to this Certificate of Coverage.
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 twenty-four (24) hour Nursing Services 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 Treatment 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 an overnight 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 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.
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	Covered Services that are received either: 1. from an In-Network Participating Practitioner and/or Provider; or 2. from a Participating Practitioner and/or Provider if an In-Network Participating Provider and/or Provider has recommended the referral and Sanford Health Plan has authorized the referral to a Participating Practitioner and/or Provider; or 3. when experiencing an Emergency Medical Condition or in an Urgent Care Situation; or 4. from a Non-Participating Practitioner and/or Provider when the Member does not have appropriate access to an In-Network Participating Practitioner and/or Provider and Sanford Health Plan has authorized the service.
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 Service for outpatient treatment 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.
Intermediate Care	Intermediate Care means care in a Facility, corporation or association licensed or regulated by the State for the accommodation of persons, who, because of incapacitating infirmities, require minimum but continuous care but are not in need of continuous medical services or Nursing Services. The term also includes Facilities for the nonresident care of elderly individuals and others who are able to live independently but who require care during the day.
Law	All applicable State and federal laws, statutes, regulations, executive orders, directives, circulars, interpretive letters and other official releases of or by any government, or any authority, department or agency thereof, including CMS, and the North Dakota Department of Insurance.

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. The Maximum Allowable Amount is the lesser of: (a) the amount charged for a covered service or supply; or (b) 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 (c) outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable: i. Fees typically reimbursed to providers for same or similar professionals; or ii. 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, to the Member's diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must: 1. 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 2. help restore or maintain the Members health; or 3. prevent deterioration of the Member's condition; or 4. prevent the reasonably likely onset of a health problem or detect an incipient problem; or 5. not considered an Experimental or Investigative Service
Member	Any individual who is enrolled in this Contract.
Mental Health and/or 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.
Minimum Essential Coverage	Any of the following types of coverage. 1. Government sponsored programs (such as Medicaid, Medicare, Medicare Advantage, CHIP, Veteran's health care programs, and Refugee Medical Assistance). 2. Student health coverage. 3. Employer sponsored health benefit plan. 4. Individual health coverage. 5. State health benefits high risk pool. 6. Other programs recognized by the U.S. Department of Health and Human Services as Minimum Essential Coverage.
Natural Teeth	Teeth, which are whole and 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 Members and that indicate a real 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	Those Health Care Services to which a Member is not entitled and are not part of the benefits paid under the terms of this Contract.
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 once a year when individuals may enroll themselves and their Dependents in coverage under the Contract.
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 Coverage	Covered Services that do not fit the definition of In-Network Coverage. Specifically: a. Out-of-Network from Non-Participating Practitioners and/or Providers when Sanford Health Plan has not authorized the referral; b. from a Participating Practitioner and/or Provider that is not "In-Network" when Sanford Health Plan has not authorized the referral; c. from a Participating Practitioner and/or Provider outside of the Sanford Health Plan Service Area when the Member is traveling outside of the covered service area for the purpose of receiving such services and: i. an In-Network Participating Practitioner and/or Provider has not recommended the referral; and ii. Sanford Health Plan has not authorized the referral to a Participating Practitioner and/or Provider outside of Sanford Health Plan's Service Area.
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, Sanford Health Plan will pay 100% of the Maximum Allowed Amount for Covered Services. The Out-of-Pocket Maximum Amount resets on January 1st of each Calendar Year. Medical and prescription drug Copay amounts apply toward the Out-of-Pocket Maximum Amount. The Out-of-Pocket Maximum Amount is set forth in the Summary of Benefits and Coverage. Your payments for Non-Covered Services do not count towards the Out-of-Pocket Maximum Amount.
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.

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.
Pharmacy Handbook	Handbook providing the out-of-pocket costs, including Copays, Deductibles, and Coinsurance that are the responsibility of the Member and a complete listing of injectable and high cost medications that require Certification.
Physician	An individual licensed to practice medicine or osteopathy.
Policy Year	The twelve (12) month period for which coverage is provided under the Certificate of Coverage. The Policy Year is a Calendar Year. However, if the Subscriber first purchases coverage after January 1, the first Policy Year shall be the prorated Calendar Year beginning on the effective date and ending on December 31 of that year.
Practitioner	A professional who provides Health Care Services. Practitioners are usually required to be licensed as required by law.
Premium	The amount paid by the Subscriber on a monthly basis for coverage for Members under this Contract.
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 Sanford Health Plan.
Primary Care Physician (PCP)	A Participating Provider who is an internist, family practice Physician, pediatrician, or obstetrician/gynecologist who is a Participating Provider 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.
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.
Provider	An institution or organization that provides services for Members. Examples of Providers include Hospitals and home health agencies.
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.

Qualified Mental Health Professional	Includes a licensed Physician who is a psychiatrist; a licensed clinical psychologist who is qualified for listing on the national register of health service Providers in psychology; a licensed certified social worker who is board-certified in clinical social work; or a nurse who holds advanced licensure in psychiatric nursing.
Qualifying Life Event or 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, 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 Sanford Health Plan, as identified in the attached Summary of Benefits and Coverage, when a Member seeks services without Certification or prior authorization when Certification/prior authorization is required.
Residential Treatment Facility	An inpatient Mental Health or Substance Use Disorder Services 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.
Serious Reportable Event	An event that results in a physical or mental impairment that substantially limits one or more major life activities of a Member or a loss of bodily function, if the impairment or loss lasts more than seven (7) calendar days or is still present at the time of discharge from an inpatient health care Facility. Serious events also include loss of a body part and death. Participating Providers are not permitted to bill Members or Sanford Health Plan for services related to Serious Reportable Events.
Service Area	The geographic Service Area identified in this Certificate of Coverage.
Skilled Nursing Facility	A Facility that is operated pursuant to the presiding state law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly licensed Physician.
Special Enrollment Period	An enrollment period that occurs outside of the Open Enrollment Period during which time Eligible Dependents who experience a Qualifying Life Event may enroll in coverage under this Contract.

Spouse	An individual to whom the Subscriber is legally married.
State	The State of North Dakota.
Subscriber	The individual in whose name the Certificate of Coverage is issued. A Subscriber is also a Member.
Summary of Benefits and Coverage or SBC	The part of this Contract that sets forth Cost Sharing, limitations and other information regarding a Member's coverage under this Contract.
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: 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 Service or treatment that is the subject of the request.
Urgent Care Situation	An Urgent Care Situation is a degree of illness or injury that is less severe than an Emergency Medical Condition, but requires prompt medical attention within twenty-four (24) hours, such as stitches for a cut finger.
Us/We	Refers to Sanford Health Plan.
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.
You	Refers to the Subscriber or Member, as applicable.

Attachment I. Summary of Benefits and Coverage

This page intentionally left blank. Please refer to your *Summary of Benefits and Coverage*, which is attached to this Certificate of Coverage.

NOTICE OF PROTECTION PROVIDED BY THE NORTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the North Dakota Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under North Dakota law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with North Dakota law, with funding from assessments paid by other insurance companies.

The protections provided by the Association are based on contract obligations up to the following amounts:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability income insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of type of coverage is $300,000; however, may be up to $500,000 with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. If coverage is available, it will be subject to substantial limitations. There are also various residency requirements and other limitations under North Dakota law. To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website at www.ndlifega.org or contact:

North Dakota Life and Health Insurance Guaranty Association
P.O. Box 2422
Fargo, North Dakota 58108

North Dakota Insurance Department
600 East Boulevard Avenue, Dept. 401
Bismarck, ND 58505

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

A written complaint to allege a violation of any provision of the Life and Health Insurance Guaranty Association Act must be filed with the North Dakota Insurance Department, 600 East Boulevard Avenue, Dept. 401, Bismarck, North Dakota 58505; telephone (701) 328-2440. Financial information for an insurance company, if the information is not proprietary, is available at the same address and telephone number and on the Insurance Department website at www.nd.gov/ndins.

Insurance companies and agents are not allowed by North Dakota law to use the existence of the Association or its coverage to sell, solicit or induce you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and North Dakota law, then North Dakota law will control.