North Dakota

Individual

Certificate of Coverage

Help understanding this document is free.
If you would like it in a different format (for example, in a larger font size), please call us at (800) 752-5863 *(toll-free)* | TTY/TDD: 711

Help in a language other than English is also free.
Please call (800) 752-5863 *(toll-free)* | TTY/TDD: 711 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.

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under this Contract is guaranteed renewable at the discretion of the Subscriber except as permitted to be canceled, rescinded, or not renewed under applicable Law and as described in Section 2 *How Coverage Ends*.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
4800 W 57th St.
Sioux Falls, SD 57108
Phone: (800) 752-5863 *(toll-free)* | TTY/TDD: 711 *(toll-free)*

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FREE HELP IN OTHER LANGUAGES

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

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

For help in a language other than English, please call us toll-free at (800) 752-5863. Both oral and written translation services are available for free in at least 150 languages.

Arabic

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

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

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

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

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

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

Karen - ဟ်သူဉ်ဟ်သး– နမ်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ် ကျိာ်အတ်မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး 800-752-5863 (TTY: 711).

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

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

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

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

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

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

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

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

NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices ("Notice") applies to Sanford Health Plan and Security Health Plan. If you have questions about this Notice, please contact Sanford's Privacy Office at (800) 325-9402. You may also email your questions to privacyoffice@sanfordhealth.org.
This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by Sanford Health Plan and Security Health Plan, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a Member under a policy or contract, or a prospective Member, obtained by Sanford Health Plan or Security Health Plan from that person or from a health care Provider is confidential and may not be disclosed except as set forth below.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

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

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

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

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

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

We may also use and share your health information for other reasons without your prior consent:
- **When required by law**: We will share information about you if State or federal law require it, including with the Department of Health and Human services if it wants to see that we're complying with federal privacy law. This may include disclosing information about victims of abuse, neglect, or domestic violence.
- **Law enforcement**: We may share information for law enforcement purposes. This includes sharing information to help locate a suspect, fugitive, missing person or witness.
- **For public health and safety**: We can share information in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone's health or safety.
- **Lawsuits and legal actions**: We may share information about you in response to a court or administrative order, or in response to a subpoena.
- **Organ and tissue donation**: We can share information about you with organ procurement organizations.
- **Medical examiner or funeral director**: We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers' compensation, correctional institutions and other government requests**: We can share information with employers for workers' compensation claims. We also share information with correctional institutions about their inmates. Information may also be shared with health oversight agencies when authorized by law, and other special government functions such as military, national security and presidential protective services.
- **Research**: We can use or share your information for certain research projects that have been evaluated and approved through a process that considers a Member's need for privacy.

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

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION

When it comes to your health information, you have certain rights.
- **Get a copy of your health and claims records:** You can ask to see or get a paper or electronic copy of your health and claims records and other health information we have about you. We will provide a copy or summary to you usually within thirty (30) calendar days of your request. We may charge a reasonable, cost-based fee. Access may be denied in some circumstances or when a certain law prohibits your access. In some circumstances you may have this decision reviewed.
- **Ask us to correct your health and claims records:** You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we'll tell you why in writing. These requests should be submitted in writing to the contact listed below.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be approved. We must say "yes" if the disclosure of your information could endanger you.
- **Ask us to limit what we use or share:** You can ask us to restrict how we share your health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the

times we've shared your health information for six (6) years prior, who we've shared it with, and why. We will include all disclosures except for those about your treatment, payment, and our health care operations, and certain other disclosures (such as those you asked us to make). We will provide one (1) accounting a year for free, but we will charge a reasonable cost-based fee if you ask for another within twelve (12) months.

- **Get a copy of this privacy notice:** You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you:** If you have a designated health care agent or medical power of attorney, or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- **File a complaint if you feel your rights are violated:** You can complain to the U.S. Department of Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.

Contact Information:

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

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

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

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

CONFIDENTIALITY OF SUBSTANCE USE DISORDER RECORDS

Specialized substance use disorder treatment at certain facilities is protected by federal law 42 CFR Part 2 (a "Part 2 Program"). Member records at a Part 2 Program, testimony about those records, or the fact an individual has been treated at a Part 2 Program may not be disclosed unless:

1. The member consents in writing;
2. The disclosure is allowed by a court order or required by other state or federal law;
3. The disclosure is needed for treatment in a medical emergency; or
4. The disclosure is related to a crime committed at a Part 2 Program, or required for suspected child abuse or neglect reporting.

You may agree to provide a general consent allowing the disclosure of Part 2 Program records for treatment, payment, and health care operations. You may also choose to revoke a previous general consent subject to certain limitations.

CALLING, TEXTING, AND EMAILING

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

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

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

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

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

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

EFFECTIVE DATE
This Notice of Privacy Practices is effective February 15, 2026.

INTRODUCTION

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

Method	Sanford Health Plan Contact Information
CALL	(800) 752-5863 *calls to this number are free*
TTY	711
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com
TRANSLATION SERVICES	(800) 752-5863
WRITE	Sanford Health Plan PO Box 91110 Sioux Falls, SD 57109-1110
PHYSICAL ADDRESS	Sanford Health Plan 4800 W 57th St. Sioux Falls, SD 57108

How to contact Customer Service

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

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

How to contact us with questions about Certification (prior authorization)

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

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

How to contact Pharmacy Management

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

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

How to contact Appeals and Grievances

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

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

How do I request an external review

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

Members have the right to contact the North Dakota Insurance Department at any time.

Method	North Dakota Insurance Department Contact Information
CALL	(800) 247-0560 (toll-free)
TTY	(800) 366-6888 (toll-free)
WRITE	North Dakota Insurance Department 600 E. Boulevard Ave. Bismarck, ND 58505-0320
EMAIL	insurance@nd.gov

MEMBER RIGHTS

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

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

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

MEMBER RESPONSIBILITIES

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

- Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible Provider. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
- Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when telephoning or contacting the Plan.
- Members are responsible for following all access and availability procedures.
- Members are responsible for seeking emergency care at an In-Network Participating Practitioner and/or Provider whenever possible. In the event an ambulance is used, direct the ambulance to the nearest participating emergency Facility unless the condition is so severe that the Member must use the nearest emergency Facility. State law requires that the ambulance transport you to the Hospital of your choice unless that transport puts you at serious risk.
- Members are responsible for notifying Sanford Health Plan of an emergency admission no later than forty-eight (48) hours after becoming physically or mentally able to give notice or as soon as reasonably possible.
- Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible Practitioner or the Hospital.
- Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health conditions, including mental health and/or substance use disorders.
- Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
- Members are responsible for notifying Sanford Health Plan within *thirty (30)* days at (800) 752-5863 *(toll-free)* | TTY/TDD: 711 *(toll-free)* of name, address, or telephone number changes.
- Members are responsible for notifying Sanford Health Plan of any changes of eligibility that may affect their membership or access to services.

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

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

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

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

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

MEDICAL TERMINOLOGY

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

DEFINITIONS
Capitalized terms are defined in Section 10 of this Policy.

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

GOVERNING LAW

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

FRAUD

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

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

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

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

INCONTESTABILITY

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

PHYSICAL EXAMINATION

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

CLERICAL ERROR

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

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

AMENDING AND TERMINATING THIS CONTRACT

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

VALUE-ADDED PROGRAM

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

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

LIMITATION PERIOD FOR FILING SUIT

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

SUMMARY OF THIS PLAN DESCRIPTION

- This Certificate of Coverage serves as your health benefits policy and describes in detail your health care benefit plan and governs the coverage.
- A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate of Coverage carefully. If you have any questions about the benefits as presented in the Certificate of Coverage, please contact Sanford Health Plan Customer Service.
- This Certificate of Coverage describes in detail the Covered Services provisions and other terms and conditions of the Plan.

NOTICE OF NON-DISCRIMINATION

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew a Certificate of Coverage, (b) terminate coverage, (c) limit benefits, or (d) charge a different Service Charge.
Sanford Health Plan:

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

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Section 504 Coordinator.

Section 504 Coordinator
2301 E. 60th Street
Sioux Falls, SD 57104

Phone: (877) 473-0911 | TTY: 711
Fax: (605) 312-9886
Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by mail, fax, phone, or email. If you need help filing a grievance, the Section 504 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

SECTION 1.
ENROLLMENT

1.1 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 of these materials will be treated by us as representations, not warranties.

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

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

1.2 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.

A. Grace Period

1. 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. We may, however, deduct the applicable Premium amount from any claims we pay during the grace period.

2. 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 Providers of the possibility for denied claims during the second and third months of the grace period. If the full Premium for all three (3) months 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.

B. 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 will be reinstated upon the forty-fifth day following our receipt of your application for reinstatement. If reinstated, this Certificate 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.

1.3 TERM AND RENEWAL

This Certificate 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 automatically 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 your or by us.

1.4 WHEN COVERAGE BEGINS

This Certificate becomes effective at 12:00 a.m. (midnight), Central Time, on the date shown on your application and your enrollment letter. Coverage begins on the day this Certificate goes into effect unless you are in the Hospital or other inpatient Facility. In that case, your coverage begins the day after your discharge from the Hospital or other inpatient Facility. A pre-existing condition waiting period may not be applied to any Member.

Before you receive benefits under this Contract, 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.

A. Fraud Warning

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.

1.5 ELIGIBILITY REQUIREMENTS

Subscriber Eligibility

To be eligible for coverage, the Subscriber must meet the eligibility requirements listed below at the time of application and throughout the Policy Year.

1. Maintain a physical place of residence in North Dakota and reside at that address 9 or more months of the year (may be required to submit documents to prove North Dakota residency);
2. Complete an application through the Federal Marketplace or directly with Sanford Health Plan;
3. Agree to abide by the terms of this Contract; and
4. Submit proof satisfactory to us to confirm Dependent eligibility.

1.6 NOTICE OF NON-DISCRIMINATION DUE TO HEALTH STATUS

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

1.7 ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

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

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

Dependent Child - 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.

To be eligible for coverage, a Dependent Child must:

- Be under twenty-six (26) years old; or
- Incapable of self-sustaining employment by reason of a disabling condition, and chiefly dependent upon the Policyholder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the Dependent Child's disability within *thirty-one (31)* days of the Plan's request.

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

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

NOTE: Dependent coverage does not include the spouse of an adult Dependent child. Coverage will continue to the end of the year* in which the Dependent Child reaches the limiting age. Until the Dependent Child attains the age of 26, the Dependent Child's marital status, financial status, residency, student

status or employment status will not be considered in determining eligibility for initial or continued coverage.
**Off-exchange plans may vary*

1.8 WHEN AND HOW TO ENROLL DEPENDENTS

A. 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(s).

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

1.9 WHEN DEPENDENT COVERAGE BEGINS

A. General

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

B. Delayed Effective Date of Dependent Coverage

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

C. Coverage from Birth

If a Subscriber has a child through birth, the child will become a covered Dependent from the date of birth, provided that coverage is applied for the child and the required Service Charge payments are made within *sixty (60)* days after the date of birth. An Eligible Member who failed to enroll during a previous enrollment period shall be covered under this Contract from the date of the child's birth, provided that coverage is applied for within *sixty (60)* days of the birth with the required notification of birth and Service Charge payments are paid.

D. Adoption or Children Placed for Adoption

If a Subscriber adopts a child or has a child placed with him or her as a Dependent, that child will become covered as a Dependent from the date of adoption, the date of entry of an order or the date of placement of the child, provided that notification of the adoption or placement for adoption coverage is applied for the child within *sixty (60)* days from either the date of adoption, the date of entry of an order or the date of placement of the child and the required Service Charge payments are paid. An Eligible Member who failed to enroll during a previous enrollment period shall be covered from the date of the child's adoption, the date of entry of an order or the date of placement of the child as noted in the legal adoption papers, provided that coverage is applied for within *sixty (60)* days of the date of adoption, the date of entry of an order or the date

of placement of the child and the required Service Charge payments are paid.

E. **New Spouses and Dependent Children**

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

1.10 NONCUSTODIAL SUBSCRIBERS

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

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

1.11 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) PROVISION

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

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

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

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

Exceptions

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

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

1.12 SPECIAL ENROLLMENT RIGHTS

A Special Enrollment Period (SEP) may apply if a Member or dependent experiences a qualifying life event. These SEPs allow a Member to enroll in or change coverage outside of the annual Open Enrollment Period.

Qualifying life events include, but are not limited to:

- Birth, adoption, or placement for adoption or foster care of a child;
- Marriage;
- Loss of minimum essential coverage (MEC) for reasons other than voluntary termination or failure to pay premiums;
- Loss of eligibility for Medicaid or the Children's Health Insurance Program (CHIP);
- Gaining or becoming a dependent through marriage, birth, adoption, or placement for adoption;
- A permanent move to a new service area where different health plan options are available;
- Changes in immigration status resulting in eligibility for enrollment;
- Other exceptional circumstances as determined by the Health Insurance Marketplace or Sanford Health Plan.

Requests for Special Enrollment must be submitted within sixty (60) days of the qualifying event. Documentation verifying the qualifying event may be required.

Loss of coverage due to non-payment of premium, voluntary termination of coverage, or rescission of coverage for cause does not qualify as a Special Enrollment Period.

SECTION 2
HOW YOU GET CARE

2.1 IDENTIFICATION CARDS

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

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

2.2 CONDITIONS FOR COVERAGE

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

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

However, this specific condition does not apply to Emergency Medical 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 situation, the Member is in the Service Area and is alert, oriented and able to communicate (as documented in medical records); the Member must direct the ambulance to the nearest In-Network Participating Practitioner and/or Provider.

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

In addition, all Health Care Services are subject to:

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

2.3 IN-NETWORK AND OUT-OF-NETWORK COVERAGE

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

1. **In-Network Coverage**; and
2. **Out-of-Network Coverage**. *For Out-of-Network coverage, please see Section 3.7.*

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

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

A member with complex care needs may have up to ninety (90) days of continued coverage subject to In-Network Cost Sharing to allow for a transition of care to an In-Network Provider. In cases where certain conditions are present – such as an acute condition, a disabling or chronic condition that is in an acute phase, life-threatening mental or physical illness, pregnancy beyond the first trimester, and physical or mental disability expected to result in death, institutional or inpatient care, and non-elective surgery – up to 120 days of coverage may be allowed to accommodate for a change of provider.

For *Appropriate Access* standards, see below.

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

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

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

2.4 APPROPRIATE ACCESS

Primary Care Physicians and Hospital Providers

Appropriate access for In-Network Participating Practitioner and/or Providers who provide primary care services and Hospital Provider sites is within 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.

Transplant Services

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

Second Opinions

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

Referrals

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

Coverage Outside the Service Area

Members who live outside of the Plan's Service Area must use the Plan's contracted Network of Participating Providers as indicated on the Provider Directory. Members who live outside the Service Area will receive Identification 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 Practitioner or Provider when appropriate access is available, claims will be processed at the Out-of-Network coverage level.

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

2.5 CASE MANAGEMENT

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

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

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

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

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

2.6 BENEFIT DETERMINATION REVIEW PROCESS

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

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

Refer to the Introduction section in the beginning of this document for instructions on how to contact the Appeals and Grievances department.

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

All pre-service benefit determination (approval) requests will be determined within seven (7) calendar days from the date the Plan receives all necessary information to evaluate the request. When a preauthorization (pre-approval) request is received before a service occurs, the date of receipt for non-urgent (standard) requests is the date the Plan receives the Member's request. If the request is made outside of business hours, the date or receipt will be next business day. If Sanford Health Plan denies a benefit (an Adverse Benefit Determination) the Plan will contact the Member via mail.

2.8 ROUTINE POST-SERVICE BENEFIT REQUESTS

Retrospective (post-service) requests occur when a Member has already utilized healthcare services and did not inquire about coverage pre-service. Post-service requests are not related documentation, coding or reimbursement from the Plan. Sanford Health Plan will review and approve or deny the service based on

Medical Necessity within thirty (30) calendar days of receipt of the request. A letter will be sent to the Member within those 30 calendar days with the Plan's determination.

2.9 UTILIZATION MANAGEMENT REVIEW PROCESS

Refer to the Introduction section at the beginning of this document for instructions on how to contact the Utilization Management department.

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

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

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

Designating an Authorized Representative

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

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

Your Right to Information

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

Your Complaint (Grievance) & Appeal Rights

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

- You may call or write the Appeals and Grievances Department. We will help you with questions about your

coverage and benefits or investigate any adverse benefit determination you might have received; or

- You may file an Appeal if you have received an Adverse Benefit Determination. Please see Section 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, beneficiary, or contracting provider. For details on the complaint and appeals process, see Section 9.

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

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

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

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

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

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

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

2.11 PHARMACY PRE-APPROVAL (CERTIFICATION) REQUESTS

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

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

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

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

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

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

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

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

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

Routine/Standard Pharmacy Pre-Approval Requests

Routine/Standard (non-urgent) pharmacy pre-approval requests will be reviewed within **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 Sanford Health Plan in alignment with the Standard and Expedited Exception Request requirements. Requests will be considered urgent if the Member's health is in serious jeopardy, or the Member's Practitioner and/or Provider states the Member may experience severe pain that cannot be controlled while waiting for the Plan's decision.

How to Request Pre-Approval for a Drug You or your authorized representative can request a medication pre-approval by:

- Contacting Pharmacy Management
- Complete Formulary Exception Form found online at sanfordhealthplan.com

- Ask the prescribing Practitioner and/or Provider for a letter of medical necessity
- Ask the prescribing Practitioner and/or Provider to contact the Plan by phone

What to Include with the Request

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

Notification of the Decision (Determination)

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

2.12 ADDITIONAL INFORMATION REGARDING FORMULARY EXCEPTION REQUESTS

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

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

2.13 MEDICAL PRE-APPROVAL (CERTIFICATION) REQUESTS

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

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

1. Member medical information including:
    a. diagnosis;
    b. medical history;
    c. presence of complications and/or co-morbidities;
2. Consultation with the treating Practitioner, as appropriate;
3. Availability of resources and alternate modes of treatment; and
4. For admissions to Facilities other than acute general Hospitals, additional information may include but is not limited to the following:

a. history of present illness;
b. patient treatment plan and goals;
c. prognosis;
d. staff qualifications; and
e. twenty-*four (24)* hour availability of qualified medical staff.

Routine Pre-Service Pre-Approval Requests

Routine/Standard (non-urgent) pre-service requests for services that require pre-approval from the Plan will be reviewed and a determination will be made within **seven (7) calendar days** from the date the Plan receives all necessary information to evaluate 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 a determination will be made no later than **seventy-two (72) hours** after the Plan receives all necessary information to evaluate 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 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.

If a Member receives an emergency health care service that requires immediate post-evaluation or post-stabilization services, the Plan shall make an authorization determination within **two (2) business days** of receiving all necessary information to evaluate the request.

How to Request Pre-Approval for a Medical Item or Health Care Service

Refer to the Introduction section at the beginning of this document for instructions on contacting the Utilization Management department to request a medical pre-approval request.

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:

- **For Urgent Requests**: request for additional information will be communicated 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.

- **For Routine/Standard Requests**: request for additional information will be communicated within **seven (7) 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 **three (3) calendar days** of the phone notification if the request is deemed urgent.
- By mail within **seven (7) calendar days** after receipt of the request.

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

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

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

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

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

Determinations by us to Limit or Reduce Previously Approved Care

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

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

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

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

Requests to Extend Previously Approved Care

A Provider who is requesting an extension of an approved ongoing course of treatment beyond the ordered period of time or number of treatments must request Prior Authorization from Sanford Health Plan at least *twenty-four (24) hours* in advance of the termination of such continuing services. Your Provider may make this request in writing or orally directly to us. To request a concurrent review determination, call Utilization Management. Refer to the Introduction section for Utilization Management contact information.

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

If the internal review process results in a denial of the request for an extension, the payment of benefits for such treatment shall terminate but the Member may pursue the appeal rights described in Section 9.

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

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

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

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

Non-Urgent (Standard) Concurrent Reviews

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

Urgent (Expedited) Concurrent Reviews

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

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

Adverse Determinations

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

Lack of Necessary Information

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

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

2.15 WRITTEN NOTIFICATION PROCESS FOR ADVERSE DETERMINATIONS

The written notifications for Adverse Determinations will include the following:

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

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

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

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

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

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

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

decision;

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

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

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

10. You have the right to contact the North Dakota Insurance Commissioner at any time.

SECTION 3
COVERED SERVICES – OVERVIEW

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

Please contact Customer Service toll-free at (800) 752-5863 | TTY/TDD: 711 (toll-free), or visit www.sanfordhealthplan.com for further details on covered services – including a price-comparison tool that compares expected out-of-pocket costs for items and services across multiple providers.

3.1 HEALTH CARE SERVICES PROVIDED BY PRACTITIONERS AND PROVIDERS

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

- *Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.*
- *Visit limits are not applicable when the primary diagnosis is Mental Health or Substance Use Disorder specific.*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *You or your Practitioner and/or Provider must get Certification of some services in this Section. The benefit description will say "**NOTE**: Certification is required for certain services. Failure to get Certification will result in a reduction or denial of benefits (See Services requiring Certification in Section 2.).*
- *See www.sanfordhealthplan.com or call 1-800-752-5863 for a list of network providers.*

3.1.1 ARTIFICIAL NUTRITION

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

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

3.1.2 ALLERGY CARE BENEFITS

- Testing and treatment
- Allergy injections
- Allergy serum

3.1.3 CARDIAC REHABILITATION

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

3.1.4 CHIROPRACTIC SERVICES

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

3.1.5 CLINICAL TRIALS

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

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

3.1.6 DIABETES SUPPLIES, EQUIPMENT AND EDUCATION BENEFITS

SHP limits out-of-pocket costs for diabetes, providing limited cost sharing for a 30-day supply of covered insulin drugs and of covered medical supplies for insulin dosing and administration.

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

Item	Information
Blood glucose test strips, glucagon, glucometers, glucose agents, lancets and lancet devices, prescribed oral agents for controlling blood sugars, syringes, urine testing strips	**Must be obtained at:** Pharmacy (prescription required) **Benefit/Cost information:** Pharmacy Benefit; deductible/coinsurance may apply
Custom diabetic shoes and inserts; Limited to one (1) pair of depth-inlay shoes and three (3) pairs of inserts; or one (1) pair of custom molded shoes (including inserts) and three (3) additional pairs of inserts	**Must be obtained at:** Durable Medical Provider **Benefit/Cost information:** Medical Benefit; deductible/coinsurance will apply
Continuous Glucose Monitor (CGM)	**Prior Authorization may be required** **Must be obtained at:** Durable Medical Provider or Pharmacy (prescription required) **Benefit/Cost information:** Pharmacy Benefit (must be on formulary and available through a pharmacy) or Medical Benefit (if obtained through a Durable Medical Provider); deductible/coinsurance may apply
Insulin Pump	**Must be obtained at:** Durable Medical Provider or Pharmacy (prescription required) **Benefit/Cost information:** Medical Benefit; deductible/coinsurance will apply

Coverage for the treatment of diabetes includes:

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

3.1.7 DIAGNOSTIC AND TREATMENT SERVICES

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

3.1.8 DIALYSIS BENEFIT

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

3.1.9 DURABLE MEDICAL EQUIPMENT (DME) BENEFITS

- Coverage is available for DME equipment prescribed by an attending Practitioner and/or Provider, which is Medically Necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury. Limitations per Sanford Health Plan policy guidelines apply.
- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Sanford Health Plan policy.
- Prior Approval is required for certain items. For updated information refer to:
    - https://www.sanfordhealthplan.org/members/prior-authorization.

3.1.10 EYE CARE/VISION SERVICES

Eye Care services are as follows:

Exams and Services	**Child** (age 0-18)	**Adult** (age 19+)
Routine eye exam • Includes dilation, if professionally indicated	One routine eye exam annually • For ages 3 to 17, the routine exam includes the Acuity and Refraction exam	Not covered
Dilated eye examination for diabetes-related diagnosis	Covered with a limit of one exam per Member per year	Covered with a limit of one exam per Member per year
Vision therapy	Covered	Covered
Services required because of injury, accident or cancer that damages the eye	Covered if the Member was covered under this Contract during the time of the injury or illness causing the damage	Covered if the Member was covered under this Contract during the time of the injury or illness causing the damage
Cataract surgery	Covered	Covered
Eye Wear (frames, lenses, contacts)	**Child** (age 0-18)	**Adult** (age 19+)
Aphakia patients: Eyeglasses or contact lenses or soft contact lenses	One (1) pair of eyeglasses, including lenses and frame per lifetime; or Two (2) single clear contact lenses per Participant per plan year	One (1) pair of eyeglasses, including lenses and frame per lifetime; or Two (2) single clear contact lenses per Participant per plan year
Scleral shells intended for the use in the treatment of a disease or injury	Soft shells limited to two (2) per calendar year; Hard shells limited to one (1) per lifetime	Soft shells limited to two (2) per calendar year; Hard shells limited to one (1) per lifetime
Prescribed lenses and frames, unless otherwise listed in the plan document	Prescribed lenses once every plan year for single vision, bifocal, trifocal, or lenticular lenses, including directly related professional services Frames limited to once every other plan year Contact lenses in lieu of the prescribed frames and/or lenses limited to $150 per plan year. Contact lenses determined to be Medically Necessary and appropriate in the treatment of patients affected by certain conditions may be covered as an additional benefit	Not covered

3.1.11 FAMILY PLANNING BENEFITS

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

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

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

3.1.12 FOOT CARE SERVICES

Routine foot care covered for Members when medically appropriate. See the section on Orthotic and prosthetic devices for information on podiatric shoe inserts.

3.1.13 HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES)

Sanford Health Plan policy guidelines apply. Coverage includes:

Exams and Services	**Child**	**Adult**
Routine hearing examination	One per Member annually	One per Member annually
Emergency and acute hearing services	Covered	Covered
Diagnosis and treatment of sudden sensorineural hearing loss (SSNHL)	Covered	Covered
Hearing Devices	**Child** (age 0-18)	**Adult** (age 19+)
NOTE: Certification may be required; failure to get Certification may result in a reduction or denial of benefits. Refer to https://www.sanfordhealthplan.com/members/prior-authorization.		
Cochlear implants and bone-anchored (hearing-aid) implants	Covered	Covered
External Hearing Aids or devices	Hearing aids, communication aids or devices for Members 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Sanford Health Plan policy guidelines apply.	External hearing aids when medically necessary for conditions including, but not limited to: sudden sensorineural hearing loss (SSNHL), accident, injury or related illness.*
Hearing aid limits	Benefit is limited to one hearing aid, per ear, per Member under 19, every three (3) years, in alignment with Medical Necessity and Sanford Health Plan guidelines	Benefit is limited to one hearing aid, per ear, per Adult Member, every three (3) years, in alignment with Medical Necessity and Sanford Health Plan guidelines. This is a DME that requires prior approval (Certification).

* The provision of hearing aids must meet criteria for rehabilitative and/or habilitative services coverage and either:

- provide significant improvement to the Member within two (2) months, as certified on a prospective and timely basis by Sanford Health Plan; or
- help maintain or prevent deterioration in physical, cognitive, or behavioral function.

3.1.14 HOME HEALTH SERVICES

The following may be covered in lieu of a Hospital or Skilled Nursing Facility stay:

- part-time or intermittent care by a RN or LPN/LVN
- part-time or intermittent home health aide services for direct patient care only
- physical, occupational, speech, inhalation, and intravenous therapies up to the maximum benefit allowable
- medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Member were Hospitalized

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

3.1.15 IMPLANTS/STIMULATORS

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

3.1.16 INFERTILITY BENEFITS

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

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

3.1.17 LAB, X-RAY AND OTHER DIAGNOSTIC TESTS

NOTE: Some of these services fall under High End Imaging and may require Certification. Failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered. Coverage includes, but is not limited to, the following

- High End Imaging services
  - CT Scans/MRI
  - PET Scans
- Blood tests
- DEXA Scans
- Electrocardiogram (EKG)
- Electroencephalography (EEG)
- Non-routine mammograms
- Non-routine Pap tests
- Non-routine PSA tests
- Pathology
- Tele-health, e-visit, and video visits benefit
- Ultrasound
- Urinalysis
- X-rays

3.1.18 NEWBORN CARE BENEFITS

A newborn child is automatically covered from the moment of birth for illness, injury, premature birth, and medically diagnosed congenital defects and birth abnormalities (Please refer to "Reconstructive Surgery" in Section 3.2 for coverage information on correcting congenital defects). This automatic coverage continues for the first thirty-one (31) days following birth.

To continue coverage beyond the initial 31-day period, you must notify the Plan and enroll the newborn within sixty (60) days of the infant's birth. If your benefit plan requires an additional payment for each Dependent, Sanford Heath Plan is entitled to all Service Charge payments due from the date of the newborn's birth. Sanford Health Plan may withhold payment of any health benefits until all required Service Charge payments you owe are paid.

If the newborn is not enrolled within sixty (60) days of birth, coverage will terminate retroactively to the thirty-first day after birth, and the Plan will not be liable for any services rendered thereafter. For more information, see Section 1 on Enrollment and *When Dependent Coverage Begins.*

3.1.19 NUTRITIONAL COUNSELING

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

Coverage includes the use of GLP1 and GIP drugs as therapy for prevention of diabetes and treatment of insulin resistance, metabolic syndrome and/or morbid obesity.

3.1.20 ONCOLOGY TREATMENT BENEFITS

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

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

3.1.21 ORTHOTIC AND PROSTHETIC DEVICES

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

- Adjustments and/or modification to the prosthesis required by wear/tear or due to a change in Member's condition or to improve the function are eligible for coverage and do not require Prior Authorization.
- Cranial Prosthesis, including wigs (limited to one per benefit period). .
- Devices permanently implanted that are not Experimental or Investigational Services such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. *This is a DME that requires Certification*
- Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Includes *two (2)* external prosthesis per Calendar Year and *six (6)* bras per Calendar Year. For double mastectomy: coverage extends to *four (4)* external prosthesis per Calendar Year and *six (6)* bras per Calendar Year. These do not require prior authorization.
- Limit of twelve (12) Prosthetic Socks per year per limb.
- Prosthetic limbs, sockets and supplies, and prosthetic eyes. *This is a DME that requires Certification*
- Repairs necessary to make the prosthetic functional are covered and do not require authorization. The expense for repairs is not to exceed the estimated expense of purchasing another prosthesis.

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

3.1.22 OTHER TREATMENT THERAPIES NOT SPECIFIED ELSEWHERE

- Inhalation Therapy
- Pheresis Therapy

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

Refer to the HEARING SERVICES (Testing, Treatment, and Supplies) section

3.1.24 PEDIATRIC (CHILD) VISION SERVICES

Refer to the EYE CARE/VISION SERVICES section

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

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

3.1.26 PHYSICAL, SPEECH, AND OCCUPATIONAL THERAPIES

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

- Physical Therapy; limited to thirty (30) visits per therapy (condition) per calendar year.
  - Additional rehabilitative therapy visits may be allowed with Prior Authorization approval.
- Occupational Therapy; limited to thirty (30) visits per therapy (condition) per calendar year.
  - Additional rehabilitative therapy visits may be allowed with Prior Authorization approval.
- Speech Therapy; limited to thirty (30) visits per therapy (condition) per calendar year.
  - Additional rehabilitative therapy visits may be allowed with Prior Authorization approval.
  - Speech therapy services must be related to a specific illness, injury, or impairment, and involve the mechanics of phonation, articulation, or swallowing. Services must be provided by a licensed or certified speech pathologist.
- Habilitative Therapy; limited to thirty (30) visits per therapy (condition) per calendar year.
  - Includes the management of limitations and disabilities and services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function.

- Includes One-to-one water therapy
- Physical therapy and Vitamin D supplements with a prescription order are covered at 100% (no cost) for Members ages 65 and older who are at increased risk for falls. Benefits are subject to Medical Necessity.

3.1.27 PRENATAL AND MATERNITY SERVICES

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

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

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

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

- Sanford Health Plan will allow one breast pump (electric or manual) per pregnancy.
- Breast pump replacement supplies, including tubing, adapters, locking rings, breast shields, splash protectors, and breast pump bottles and caps, are covered.
- Breast milk storage bags are covered.
- Bottles which are not specific to breast pump operation and all associated supplies are NOT covered.

- Pumps and supplies are covered only when obtained from a Sanford Health Plan In-Network Participating Practitioner and/or Provider. This does NOT include drugstores or department stores.

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

Newborns' and Mothers' Health Protection Act Disclosure

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

NOTE: We encourage you to participate in our Healthy Pregnancy Program. Visit sanfordhealthplan.com/members/wellness/healthypregnancy to enroll. If you have questions, please contact our care management team Monday through Friday from 8 a.m. to 5 p.m. CST at (888) 315-0884 (TTY: 711).

3.1.28 PREVENTIVE CARE, ADULTS & CHILDREN

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

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF); except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009. Which includes;
    a. One baseline mammogram, or more if ordered by a physician, for individuals who are at least thirty-five (35) years of age but less than forty (40) years of age, and one mammogram every year, or more frequently if ordered by a physician, for individuals who are at least forty (40) years of age;
    b. One prostate screening for asymptomatic men aged fifty (50) and over, African American men aged forty (40) and over, and men aged forty (40) and over with a family history of prostate cancer.
2. Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Member involved;
3. With respect to covered persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to covered persons who are women, such additional preventive care and screenings not described in paragraph (1) above as provided for in comprehensive guidelines supported by the Health

Resources and Services Administration. You do not need prior authorization from Sanford Health Plan or any other person in order to obtain access to obstetrical and/or gynecological care through an In-Network Participating Practitioner and/or Provider.

The above is an overview of preventive services covered by Sanford Health Plan. As recommendations change, your coverage may also change. To view Sanford Health Plan's Preventive Health Guidelines, visit www.sanfordhealthplan.com/memberlogin. You may also request a copy by calling Customer service at (800) 752-5863 (toll-free) | TTY/TDD: 711 (toll-free).

3.1.29 PRIVATE DUTY NURSING

NOT COVERED

3.1.30 TRANSGENDER HEALTH SERVICES

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

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

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

Under ND state law a health care provider in ND may not engage in certain prohibited practices for the purpose of changing or affirming a minor's perception of their sex. Please inquire with us for further questions regarding this benefit in ND or outside of ND.

3.1.31 TELEHEALTH SERVICES (VIRTUAL VISITS)

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

- The encounter involves a qualifying CPT code (Current Procedural Terminology) that the Health Plan has approved to be conducted by telehealth.
- The services are medically necessary and meet the definition of Covered Health Services as described in this Plan document.
- The technology platform used for the encounter is HIPAA (Health Insurance Portability and Accountability Act) compliant.
- The technology platform used for the encounter allows for fully synchronous, real-time, audio-video connection between the patient and the provider for the duration of the encounter.

- If the patient is physically present with one provider (host location) and is being connected to a remote (distant) provider, charges by the host provider as an originating site to facilitate the connection with the distant provider performing the service are also eligible for coverage, as well as the qualifying charges from the distant provider for conducting the telehealth encounter.

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

3.1.32 TOBACCO CESSATION TREATMENT BENEFITS

Tobacco cessation treatment coverage is as follows:

- Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force when received from an In-Network provider are covered without payment of any Deductible, Copay, or Coinsurance requirement that would otherwise apply.
- Tobacco cessation treatment includes:
    - Screening for tobacco use; and
    - At least two (2) tobacco cessation attempts per year (for Members who use tobacco products).
        - Covering a cessation attempt is defined to include coverage for:
            - Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization, and
            - One ninety (90) day treatment regimen of all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a Health Care Provider without prior authorization.

3.2 SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY

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

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

3.2.1 ADMISSIONS

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

The following Hospital Services are covered:

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

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

3.2.2 ANESTHESIA

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

3.2.3 HOSPICE CARE

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

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

3.2.4 ORAL AND MAXILLOFACIAL SURGERY

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

- Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.*
    - Care must be received within *twelve (12)* months of the occurrence
- Orthognathic Surgery per Sanford Health Plan guidelines. *This is an Outpatient Surgery that requires Certification*
    - Associated radiology services are included
    - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
    - Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
    - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
    - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
    - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
        - Splint limited to one (1) per Member per benefit period.
- Anesthesia and Hospitalization charges for dental care that are charged as an Outpatient Service require Certification (Prior Authorization) if a Member:
    - is a child age fourteen (14) or older (Certification is not required for children under age 14); or
    - is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician; or
    - has a medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

3.2.5 OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER

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

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

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

3.2.6 RECONSTRUCTIVE SURGERY

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

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

3.2.7 SKILLED NURSING CARE FACILITY BENEFITS

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

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

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

3.2.8 TRANSPLANT SERVICES

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

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

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

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

3.3 EMERGENCY SERVICES/ACCIDENTS

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

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

3.3.1 BENEFIT DESCRIPTION

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

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

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

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

3.3.2 EMERGENCY WITHING OUR SERVICE AREA

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

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

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

We cover emergency services necessary to screen and stabilize members without pre-Certification in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. With respect to care

obtained from a Non-Participating Provider within the Service Area, we cover emergency services necessary to screen and stabilize a Member, and may not require Prospective (pre-service) Review of such services if a Prudent Layperson would have reasonably believed that use of an In-Network Participating Practitioner and/or Provider would result in a delay that would worsen the emergency; or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

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

Under the No Surprises Act, for emergency services furnished by a nonparticipating emergency facility or provider, the individual's cost sharing is generally calculated as if the total amount that would have been charged for the services by a participating emergency facility or provider were equal to the recognized amount for such services.

For non-emergency services furnished by nonparticipating providers in a participating health care facility, the individual's cost sharing is generally calculated as if the total amount that would have been charged for the services by a participating facility or provider were equal to the recognized amount for such services.

See Section 10 of this Policy for definition of the terms used in this section.

3.3.3 EMERGENCY OUTSIDE OUR SERVICE AREA

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

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

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

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

3.3.4 AMBULANCE AND TRANSPORTATION SERVICES

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

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

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

Members who receive emergent air ambulance services will be covered at In-Network rates. Planned or scheduled air ambulance services must be prior-authorized by the Plan. In both instances, Members will not be held liable for additional cost-sharing, including from Out-of-Network Providers.

3.4 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

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

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

3.4.1 MENTAL HEALTH BENEFITS

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

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

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

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

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

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

3.4.2 APPLIED BEHAVIOR ANALYSIS FOR TREATMENT OF AUTISM SPECTRUM DISORDER

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

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

1. Member must be diagnosed with Autism Spectrum Disorder by a Provider and/or Practitioner qualified to diagnose the condition.
2. ABA as behavioral health treatment is expected to result in the achievement of specific improvements in the Member's functional capacity of their autism spectrum disorder, subject to Plan medical policy and medical necessity guidelines
3. ABA services are only covered when provided by a licensed or certified practitioner as defined by law.
4. Coverage of ABA may be 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.

3.4.3 SUBSTANCE USE DISORDER BENEFITS

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

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

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

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

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

3.5 OUTPATIENT PRESCRIPTION DRUG BENEFITS

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

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

Refer to the Introduction section at the beginning of this document for instructions on how to contact Pharmacy Management.

3.5.1 BENEFIT DESCRIPTION

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

the Member. If an exception is granted, coverage of the non-formulary drug will be provided for the duration of the prescription, including refills. See Pharmaceutical Review Requests and Exception to the Formulary Process in Section 2 for details.

- With certain medications, the Plan requires a trial of first-line medications, typically generics, before more expensive name brand medications are covered. If the desired clinical effect achieved or a side effect is experienced, then a second line medication may be tried. If a step therapy rule is not met at the pharmacy, coverage will be determined by Prior Authorization (pre-approval) Review. Request Prior Authorization by contacting Pharmacy Management. Refer to the Formulary for a complete list of medications that require step therapy.
- Members may receive comprehensive medication management services from a pharmacist if at least one of the following criteria are met:
    - taking five or more chronic medications;
    - admitted to the hospital with heart failure, pneumonia, myocardial infarction, mood disorder, or chronic pulmonary disorder; or
    - has active diagnosis of comorbid diabetes and hypertension or hyperlipemia.
- 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. Refer to the formulary for a complete list of medications that require Prior Authorization.
- Certain medications have a quantity limit to ensure the medication is being used as prescribed and the member is receiving the most appropriate treatment based on manufacturer's safety and dosing guidelines. Refer to your formulary for a complete list of medications with quantity limits.
- Prescriptions will be filled for up to a thirty (30) day supply per copay (or less, if prescribed) at one time (unless otherwise approved by the Plan).
- Prescription refills will be covered when 75% of your prescription has been used up with a surplus limit of 10 days. The surplus limit is calculated based on the amount of medication obtained over the previous 180 days and limits you to a maximum of 10 days of additional medication at any given time.
- 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).
- GLP-1 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 are 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. Contact Pharmacy Management to request a vacation override.
- If you receive a brand name drug when there is a generic equivalent or biosimilar alternative available, you will be required to pay a brand penalty. The brand penalty consists of the price difference between a brand name drug and the generic equivalent or biosimilar alternative, in addition to applicable cost sharing (copay and/or deductible/coinsurance) amounts. Brand penalties do not apply to your deductible or maximum out of pocket.

- Authorized generic drugs may not be placed on the generic formulary tier. An authorized generic is the brand company's own product repackaged and marketed as a generic drug. An authorized generic is a brand-name drug.
- There are no limitations or restrictions for use of manufacturer coupons if used in conjunction with our current benefit offering.
- For participants enrolled in a High Deductible Health Plan, the prescription drug benefit is subject to your deductible and coinsurance amounts.

3.5.2 COVERED MEDICATIONS AND SUPPLIES

To be covered by the Plan, prescriptions must be:

1. Prescribed or approved by a licensed physician, physician assistant, nurse practitioner or dentist;
2. Listed in the Plan Formulary, unless certification (authorization) is given by the Plan;
3. Provided by an In-Network Participating Pharmacy except in the event of emergent medical situations (if a prescription is filled at a Non-Participating and/or Out-of-Network Pharmacy in non-emergent medication situations, the Member will be responsible for the cost of the prescription medication in full);
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

3.5.3 COVERED TYPES OF PRESCRIPTIONS

- Federal Legend Drugs. Any medicinal substance which bears the legend: "Caution: Federal Law prohibits dispensing without a prescription," except for those medicinal substances classified as exempt narcotics pursuant to applicable laws and regulations.
- Self-Administered medications- medications such as subcutaneous injections, oral or topical medications, or nebulized inhalation are to be obtained from a Network Pharmacy
- Medicinal substances (legally restricted medications) that may only be dispensed by a prescription, according to applicable laws and regulations
- Compounded medications are only covered when the medication has at least one ingredient that is a federal legend or state restricted drug in a therapeutic amount.
- Diabetic supplies, such as insulin, a blood glucose meter, blood glucose test strips, diabetic needles and syringes are covered when medically necessary. (See the DIABETES SUPPLIES, EQUIPMENT AND EDUCATION BENEFITS section for more information.)
- Self-Administered medications- hormonal contraceptives, nicotine replacement medications, and opiate antagonists for the treatment of an acute opiate overdose prescribed by an appropriate Practitioner and/or Provider, including a licensed pharmacist, and obtained from a Network Pharmacy.

3.6 DENTAL BENEFITS

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

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

3.6.1 BENEFIT DESCRIPTION

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

- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
    - Services for the Treatment and Diagnosis of TMJ/TMD subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
    - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers and is Medically Necessary pursuant to Sanford Health Plan's medical coverage guidelines.
    - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
        - Splint limited to one (1) per Member per benefit period.
- Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth, as long as the Member was covered under this Contract during the time of the injury or illness causing the damage. This is an Outpatient Surgery that requires Certification.
    - Care must be received within 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
- Anesthesia and Hospitalization charges for dental care that are charged as an Outpatient Service require Certification (Prior Authorization) if a Member:
    - is a child fourteen (14) or older (Certification is not required for children under age 14); or
    - is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician; or
    - has a medical condition(s) as determined by a licensed Physician that places the Member at serious risk.
- Coverage for diagnosis and treatment of periodontal disease in acute or chronic disease state if recommended by a board-certified medical practitioner based on health-related impacts or on further deterioration in

disease state due to gum disease, including treatment that arises as a result of the periodontal treatment such as crowns.

3.6.2 PEDIATRIC (CHILD) DENTAL CARE

Coverage is provided for emergency, preventive and routine 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 nineteen (19). Covered pediatric services include:

Pediatric Diagnostic Services

- Routine oral evaluations allowed twice during calendar year
- Full mouth X-rays allowed once every three (3) years
- Bitewing X-rays allowed twice during calendar year
- Single tooth X-rays as medically indicated

Pediatric Preventive Services

- Prophylaxis (cleanings) allowed twice 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 one (1) sealant per tooth every three (3) years
- Space maintainers

Pediatric Restorative Services

- Fillings once every two (2) years per surface per tooth
- Inlays, onlays and crowns (not part of a fixed partial Denture) limited to one (1) per tooth every five (5) years

Pediatric Endodontics

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

Pediatric Periodontics

- Periodontal surgery
- Periodontal scaling and root planning once every two (2) years, per quadrant
- Gingivectomy or gingivoplasty, four (4) or more teeth limited to one every three (3) years

Pediatric Prosthodontics

- Dentures (complete and partial) once every five (5) years
- Tissue conditioning
- Relining of immediate dentures once during the year after insertion
- Relining or rebasing of complete and partial dentures other than in item above, allowed once every three (3) years.
- Medically Necessary implants limited to one (1) every five (5) years

Pediatric Oral And Maxillofacial Surgery

- Simple extractions
- Surgical extractions (includes wisdom tooth extraction when medically necessary)
- 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

3.7 OUT-OF-NETWORK BENEFITS

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

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

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

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

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

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

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

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

SECTION 4
LIMITED AND NON-COVERED SERVICES

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

4.1 GENERAL MEDICAL EXCLUSIONS

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

24. Charges for sales tax, mailing, interest and delivery
25. Charges for services determined to be duplicate services
26. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner and/or Provider or electronic consultations, unless otherwise stated in this Certificate of Coverage
27. Charges that exceed the Maximum Allowed Amount for Non-Participating Providers
28. Chemical peel for acne
29. Chiropractic manipulations for allergies
30. Clarification of simple instructions
31. Commodes and/or similar convenience items
32. Complications resulting from non-covered or denied Health Care Services.
33. 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)
34. 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
35. Convalescent care
36. Conversion therapy
37. Cosmetic Services and/or supplies to repair or reshape a body structure not Medically Necessary and/or primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, cosmetic dental services, and body contouring procedures, and body lift procedures, with the exception of WHRCA for coverage of services related to breast cancer
38. Cosmetic services such as facial feminization/masculinization surgery; including but not limited to including but not limited to liposuction, lipofilling, voice modification therapy/surgery, trachea shave/thyroid chondroplasty, gluteal augmentation, hair removal, pectoral implants, or other aesthetic procedures
39. Costs related to locating organ donors
40. Coverage beyond one (1) piece of same-use equipment (e.g. mobilization, suction), unless replacement is covered under the replacement guidelines in this policy. Duplicate or back up equipment is not a covered benefit.
41. Cryogenic or other preservation techniques used in such or similar procedures;
42. Custodial care
43. Custodial or convalescent care
44. Daycare, Attendant, or Homemaker Services
45. Deluxe equipment
46. Dental appliances of any sort, including but not limited to those related to Sleep Apnea (except mandibular advancement devices (MADs)), bridges, braces, and retainers that are for cosmetic reasons and/or medically unnecessary
47. Dental care and treatment (routine or non-routine) for Members ages nineteen (19) and older including but not limited to:
    a. natural Teeth replacements including crowns, bridges, braces or implants;
    b. extraction of wisdom teeth; hospitalization for extraction of teeth;
    c. dental x-rays or dental appliances;
    d. shortening of the mandible or maxillae for cosmetic purposes;
    e. services and supplies related to ridge augmentation, implantology, and preventive vestibuloplasty; and
    f. dental appliances of any sort, including but not limited to bridges, braces, and retainers, other than for treatment of TMJ/TMD

48. Dental services not specifically listed as Covered by the Policy
49. Dental x-rays
50. Diet therapy (specialty foods) for allergies
51. Dietary desserts and snack items
52. Dietary surveillance and counseling, unless part of a wellness visit
53. Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage
54. Domiciliary care or Long-Term Residential Care
55. Donor expenses for complications of transplants that occur after sixty (60) days from the date an organ is removed, regardless if the donor is covered as a Member under this Plan or not
56. Duplicate or similar items
57. Duplicate services, including allergy testing for percutaneous scratch tests, intradermal tests, and patch tests
58. 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)
59. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to,
    a. Education on self-care or home management
    b. Educational or non-medical services for learning disabilities
    c. Educational or non-medical services for learning disabilities and/or behavioral problems, including those educational or non-medical services as provided under the Individuals with Disabilities Education Act (IDEA)
    d. Educational or non-medical services for learning disabilities or behavioral problems
60. Elective abortion services, except in cases of rape, incest, or when mother's life is endangered. Prior Authorization/certification required.
61. Elective extraction of wisdom teeth
62. Enclosure beds (e.g., Cubby Bed, Sleep Safe Bed, Posey Bed, Vail Enclosure Bed)
63. Expenses incurred by a Member as a donor, unless the recipient is also a Member
64. Experimental and Investigational Services not part of an Approved Clinical Trial unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies
65. Extra care costs related to taking part in an Approved Clinical Trial such as additional tests that a Member may need as part of the trial, but not Routine Patient Costs.
66. First aid or precautionary equipment such as standby portable oxygen units
67. Food items for medical nutrition therapy
68. Formula and supplements available Over the Counter
69. Hair transplants or hair plugs
70. Health Care Services covered by any governmental agency/unit for military service-related injuries/diseases, unless applicable law requires primary coverage for the same
71. 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
72. 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
73. Health Care Services ordered by a court or as a condition of parole or probation, unless applicable law requires the Plan to provide coverage for the same
74. Health Care Services performed by any Provider who is a Member of the Member's immediate family, including any person normally residing in the Member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only In-Network Participating Practitioner and/or Provider in the area, the Member may be treated by that Provider provided they are acting within the scope of their practice. The Member may also go to a Non-

Participating Provider and receive In-Network coverage (Section 2). If the immediate family member is not the only In-Network Participating Practitioner and/or Provider in the area, the Member must go to another In-Network Participating Practitioner and/or Provider in order to receive coverage at the In-Network level.

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

107. Marriage counseling; pastoral counseling; financial or legal counseling; and custodial care counseling
108. Maternity classes and/or education programs
109. Meals, custodial care or housekeeping
110. Milieu therapy
111. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events. Participating Providers are not permitted to bill Members for services related to such events.
112. Newborn delivery and nursery charges for adopted Dependents prior to the adoption-bonding period
113. Non-licensed birthing assistance, such as doulas
114. Non-surgical treatments that do not meet the Plan's Medically Necessary guidelines (available upon request)
115. Nursing care requested by, or for the convenience of the Member or the Member's family (rest cures)
116. Nutritional or food supplements (services supplies and/or nutritional sustenance products or food related to enteral feeding, except when it's the sole means of nutrition)
117. Online assessment and management service provided by a qualified non physician health care professional, internet or electronic communications.
118. Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliances
119. Panniculectomy that does not meet Plan guidelines
120. Personal comfort items (telephone, television, guest meals and guest beds)
121. PKU dietary desserts and snack items
122. Provider-initiated e-mail
123. Provocative food testing
124. Refractive errors of the eye
125. Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other Health Care Services
126. Reminders of scheduled office visits
127. Remote control devices as optional accessories
128. Removal of skin tags
129. Removal, revision or re-implantation of saline or silicone implants for: breast implant malposition; unsatisfactory aesthetic outcome; Member desire for change of implant; Member fear of possible negative health effects; or removal of ruptured saline implants that do not meet Medical Necessity criteria
130. Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness; or if lost or stolen
131. Replacement or repair of items, if the items are damaged or destroyed by the Member's misuse, abuse or carelessness; or if lost or stolen
132. Reproductive Health Care Services prohibited by the laws of This State
133. Requests for a referral
134. Research costs related to conducting the Approved Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trials; Sanford Health Plan does not cover these costs.
135. Rest cures
136. Restorative replacements including crowns, bridges, braces or implants (unless otherwise specified as covered in this Policy)
137. Reversal of voluntary sterilization
138. Reversals of prior sterilization procedures
139. Revision of durable medical equipment, except when made necessary by normal wear or use
140. Revision/replacement of prosthetics (except as noted per Plan policy)
141. Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates

142. Self-help and adaptive aids are not a covered benefit, including assistive communication devices and training aids
143. Sensitivity training
144. Sequela, which are primarily cosmetic that occur secondary to a weight loss procedure (e.g., Panniculectomy, breast reduction or reconstruction)
145. Service call charges and charges for repair estimates
146. Services and supplies related to ridge augmentation, implantology, and preventive vestibuloplasty
147. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home that are not Medically Necessary
148. Services determined to be cosmetic by the Plan
149. Services for excluded benefits
150. Services for which the Member has no legal obligation to pay or for which no charge would be made if the Member did not have health plan or insurance coverage.
151. Services not medically appropriate or necessary
152. Services not medically appropriate to do via telehealth
153. 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
154. Services provided in the Member's home for convenience
155. Services related to environmental change
156. Services that are not Health Care Services
157. Services that are the responsibility of a Third Party Payor or are not billable to health insurance
158. Services that can be provided safely and effectively by a non-clinically trained person
159. Services that involve payment of family members or nonprofessional care givers for services performed for the member
160. Services to assist in activities of daily living
161. 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
162. Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by the Plan's Chief Medical Officer or its designee
163. Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating Center of Excellence
164. Shortening of the mandible or maxillae for cosmetic purposes
165. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered
166. 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)
167. Storage of stem cells including storing umbilical cord blood of non-diseased persons for possible future use
168. Sublingual allergy desensitization
169. Subsequent surgeries when no tangible evidence of Medical Necessity or improved quality of life exists.
170. Surgical procedures that can be done in a Practitioner office setting (i.e. vasectomy, toe nail removal)
171. Take-home drugs
172. Telecommunication Devices
173. Telephone assessment and management services
174. Tests considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: allergy testing, celiac antibody testing, hair analysis, testing for mitochondrial disorders, and micronutrient testing

175. Therabands, cervical pillows, traction services
176. Therapies considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: auditory integration therapy, biofeedback, chelation therapy, hippotherapy, equestrian therapy, and hyperbaric oxygen therapy
177. Therapy and service animals, including those used for emotional or anxiety support
178. Tinnitus Maskers
179. Transfers performed only for the convenience of the Member, the Member's family, or the Member's Practitioner and/or Provider
180. Transmission fees
181. Transplant evaluations with no end organ complications
182. Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria
183. Transportation costs for non-emergency services and/or travel
184. 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
185. Treatment of weak, strained, or flat feet
186. Treatment received outside of the United States
187. 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.
188. Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier
189. Vitamins and minerals (unless otherwise specified as covered in this Policy)
190. Voluntary or involuntary drug testing unless a part of a Plan approved treatment plan
191. Wearable artificial kidney, each
192. Weight loss or exercise programs or equipment that do not meet the Plan's Medical Necessity coverage guidelines
193. Treatment received outside the Service Area, other than during an Emergency Medical Situation, if a Member travels out of the Service Area for the purpose of seeking medical treatment, unless care is received from an In-Network Participating Practitioner and/or Provider.

4.2 GENERAL PHARMACY EXCLUSIONS

1. Any medication equivalent to an OTC medication except for drugs that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and only when prescribed by a health care Practitioner and/or Provider
2. Compound medications containing any combination of the following: Baclofen, Bromfenac, Bupivicaine, Cyclobenzaprine, Gabapentin, Ketamine, Ketoprofen or Orphenadrine
3. Compound medications with no legend (prescription) medication
4. Drug Efficacy Study Implementation ("DESI") drugs
5. Drugs approved under the Federal Food and Drug Administration (FDA) Accelerated Approval Program, unless medically necessary or required by law.
6. Experimental or Investigational medications or medication usage pursuant to the Plan's medical coverage policies
7. Food supplements and baby formula (except to treat phenylketonuria (PKU) or otherwise required to sustain life), nutritional and electrolyte substances
8. Lifestyle medications used to treat sexual dysfunction, impotence, or sexual inadequacy or to enhance sexual pleasure, intimacy or relationship enhancement

9. Medical Cannabis and/or its equivalents
10. Medication used to treat infertility
11. 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)
12. Medications for cosmetic purposes, including baldness, removal of facial hair, or pigmenting or anti-pigmenting of the skin
13. Medications not listed in the Plans Formulary
14. Medications obtained at a Non-Participating and/or Out-of-Network Pharmacy;
15. Medications that are obtained without Prior Authorization or a Formulary exception from the Plan
16. Medications that may be received without charge under a government program, unless coverage is required for the medication
17. Medications that provide little or no evidence of therapeutic advantage over other products available
18. 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;
19. Orthomolecular therapy, including nutrients or vitamins unless otherwise specified as covered in this document
20. 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
21. Refills of any prescription older than one (1) year
22. Repackaged medications
23. Replacement of a prescription medication due to loss, damage, or theft
24. Self-administered medications dispensed in a Provider's office or non-retail pharmacy location
25. Unit dose packaging
26. Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia

4.3 SPECIAL SITUATIONS AFFECTING COVERAGE

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

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

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

4.4 SERVICES COVERED BY OTHER PAYORS

The following are excluded from coverage:

- Health Care Services for which other coverage is either (1) required by federal, state or local law to be purchased or provided through other arrangements or (2) has been made available to and was purchased by the Covered Person. Examples include coverage required by Worker's compensation, no-fault auto insurance, medical payments coverage or similar legislation.
- The Certificate of Coverage is not issued in lieu of nor does it affect any requirements for coverage by Worker's Compensation. This Certificate of Coverage contains a limitation, which states that health services for injuries or sickness, which are job, employment or work, related for which benefits are paid under any Worker's Compensation or Occupational Disease Act or Law, are excluded from coverage under this Certificate of Coverage. However, if benefits are paid under the Certificate of Coverage, and it is determined that Member is eligible to receive Worker's Compensation for the same incident; Sanford Health Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Member will consent to reimburse Sanford Health Plan the full amount of the Reasonable Costs when entering into any settlement and compromise agreement, or at any Worker's Compensation Division Hearing. Sanford Health Plan reserves its right to recover against Member even though:
    - The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise; or
    - No final determination is made that the injury or sickness was sustained in the course of or resulted from employment;
    - The amount of Worker's Compensation for medical or health care is not agreed upon or defined by Member or the Worker's Compensation carrier; or
    - The medical or health care benefits are specifically excluded from the Worker's Compensation settlement or compromise.
- Member will not enter into a compromise or hold harmless agreement relating to any work related claims paid under the Certificate of Coverage, whether or not such claims are disputed by the Worker's Compensation insurer, without the express written agreement of Sanford Health Plan.
- Health Care Services for conditions that under the laws of This State must be provided in a governmental institution.

4.5 SERVICES AND PAYMENTS THAT ARE THE RESPONSIBILITY OF MEMBER

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

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

5.1 REIMBURSEMENT OF CHARGES BY PARTICIPATING PROVIDERS

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

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

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

5.2 REIMBURSEMENT OF CHARGES BY NON-PARTICIPATING PROVIDERS

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

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

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

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

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

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

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

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

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

5.3 BALANCE BILLING FROM NON-PARTICIPATING PROVIDERS

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

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

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

5.4 HEALTH CARE SERVICES RECEIVED OUTSIDE OF THE UNITED STATES

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

5.5 TIMEFRAME FOR PAYMENT OF CLAIMS

- The payment for reimbursement of the Member's costs will be made within *fifteen (15)* days of when Sanford Health Plan receives a complete written claim with all required supporting information.
- When a Member receives Covered Services from a Non-Participating Provider and payment is to be made according to our guidelines, Sanford Health Plan will arrange for direct payment to either the Non-Participating Provider or the Member. If the Provider refuses direct payment, the Member will be reimbursed for the Maximum Allowed Amount of the services in accordance with the terms of This Contract. The Member will be responsible for any expenses that exceed Maximum Allowed Amount, as well as any Copay, Deductible, or Coinsurance required for the Covered Service.

5.6 WHEN WE NEED ADDITIONAL INFORMATION

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

SECTION 6
COORDINATION OF BENEFITS

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

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

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

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

6.1 APPLICABILITY

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

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

The benefits of this Plan:

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

6.2 DEFINITIONS (FOR COB PURPOSES ONLY)

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

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

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

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

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

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

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

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

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

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

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

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

6.3 ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

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

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

- The primary plan is the plan of the parent whose birthday is earlier in the year if:
- The parents are married;
- The parents are not separated (whether or not they even have been married); or

- A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

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

If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after The Plan is given notice of the court decree.

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

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

6.4 EFFECT OF COB ON THE BENEFITS OF THIS PLAN

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

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

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

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

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

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

Facility of Payment. A payment made under another plan may include an amount that should have been paid under this Plan. If it does, the Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this Plan. The Plan will not have to pay that amount

again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means reasonable cash value of the benefits provided in the form of services.

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

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

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

6.5 CALCULATION OF BENEFITS, SECONDARY PLAN

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

6.6 COORDINATION OF BENEFITS WITH GOVERNMENT PLANS AND BENEFITS

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

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

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

6.7 COORDINATION OF BENEFITS WITH MEDICARE

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

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

When MSP Rules Apply to COB

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

Coordination with Medicare Part D

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

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

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

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

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

When Medicare is primary despite the MSP rules:

- A Medicare-entitled person refuses coverage under the Plan;*
- Medical services or supplies are covered by Medicare but are excluded under the group health plan;
- A Medicare-entitled person has exhausted his or her benefits under the group health plan;
- A person entitled to Medicare for any reason other than ESRD, experiences a COBRA qualifying event, and elects COBRA continuation;
- A person who was on COBRA becomes entitled to Medicare for a reason other than ESRD, and his or her COBRA coverage ends.

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

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

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

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

6.8 MEMBERS WITH END STAGE RENAL DISEASE (ESRD)

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

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

How Primary vs. Secondary is Determined:
The Plan will coordinate benefits with Medicare in accordance with applicable federal law. In situations where no such coordination period is required, Medicare will be considered the primary payor, and the Plan will coordinate benefits accordingly. The Plan reserves the right to coordinate benefits consistent with applicable law and plan design.

6.9 COORDINATION OF BENEFITS WITH MEDICAID

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

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

6.10 COORDINATION OF BENEFITS WITH TRICARE

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

- Sanford Health Plan pays first if an individual is covered by both TRICARE and Sanford Health Plan, as either the Member or Member's Dependent; and a particular treatment or procedure is covered under both benefit plans.
- TRICARE will pay last; TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim.
- When a TRICARE beneficiary is covered under Sanford Health Plan, and also entitled to either Medicare or Medicaid, Sanford Health Plan will be the primary payer, Medicare/Medicaid will be secondary, and TRICARE will be tertiary (last).

SECTION 7
SUBROGATION AND RIGHT OF REIMBURSEMENT

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

Subrogation Defined

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

Reimbursement Defined

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

Covered Individuals

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

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

7.1 SANFORD HEALTH PLAN'S RIGHTS OF SUBROGATION

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

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

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

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

7.2 SANFORD HEALTH PLAN'S RIGHT TO REDUCTION AND REIMBURSEMENT

Sanford Health Plan shall have the right to reduce or deny benefits otherwise payable by Sanford Health Plan, or to recover benefits previously paid by Sanford Health Plan, to the extent of any and all payments made to or for a Member by or on behalf of a third party who is or may be liable to the Member, regardless of whether such

payments are designated as payment for, but not limited to, pain and suffering, loss of income, medical benefits or expenses, or other specified damages.

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

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

7.3 ERRONEOUS PAYMENTS

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

7.4 MEMBER'S RESPONSIBILITIES

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

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

Any Member who fails to cooperate in Sanford Health Plan's administration of this Part shall be responsible for the reasonable cost for services subject to this section and any legal costs incurred by Sanford Health Plan to enforce its rights under this section. Sanford Health Plan shall have no obligation whatsoever to pay medical benefits to a Covered Individual if a Covered Individual refuses to cooperate with Sanford Health Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as Sanford Health Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Covered Individual is a minor, Sanford Health Plan shall have no obligation to pay any medical benefits incurred on account of injury or illness caused by a third-party until after the Covered Individual or his or her authorized legal representative obtains valid court recognition and approval of Sanford Health Plan's 100%, first-dollar Subrogation and refund rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Members must also report any recoveries from insurance companies or other persons or organizations arising form or relating to an act or omission that caused or contributed to an injury or illness to the Member paid for by

Sanford Health Plan. Failure to comply will entitle Sanford Health Plan to withhold benefits, services, payments, or credits due under Sanford Health Plan.

7.5 SEPARATION OF FUNDS

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

7.6 PAYMENT IN ERROR

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

SECTION 8
HOW COVERAGE ENDS

8.1 TERMINATION 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, your coverage will terminate at 11:59 pm, Central time, on the last day of the month in which any of the following events occur.

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 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 Division 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.

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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.

8.2 EFFECTS OF TERMINATION

If this Certificate of Coverage or coverage of a Member is terminated for fraud, 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 misrepresentation.
3. May, at its option, declare 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 11:59 p.m. Central Time on the day this Contract is terminated. Termination of coverage for the Subscriber constitutes termination of the Contract and coverage for all Members shall cease.

8.3 MEMBER APPEAL OF TERMINATION

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

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

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

8.4 CHANGES IN ELIGIBILITY

A. 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.

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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.

B. 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.

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SECTION 9
PROBLEM RESOLUTION

9.1 MEMBER APPEAL PROCEDURES - OVERVIEW

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

Claims for benefits under this Certificate of Coverage can be post-service, pre-service, or concurrent. This Section of your Summary Plan Description explains how you can file a complaint regarding services provided by Sanford Health Plan; or appeal a partial or complete denial of a claim. For information on medication/drug Formulary exception requests, see Section 4, *Pharmaceutical Review Requests and Exception to the Formulary Process*.

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

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

Special Communication and Language Access Services

For Members who request language services, Sanford Health Plan will provide services at no charge in the requested language through an interpreter. Translated documents are also available at no charge to help Members submit a complaint or appeal, and Sanford Health Plan will communicate with Members free of charge about their complaint or appeal in the Member's preferred language, upon request. To get help in a language other than English, call (800) 752-5863.

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 711.

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Maximum Appeal Timelines			
Type of Notice	**Emergency**	**Pre-Service**	**Post-Service**
Initial Determinations	72 Hours	7 Days	30 Days
Request for Internal Appeal (Member)	180 Days	180 Days	180 Days
Additional Information Request (Plan)	24 Hours	15 Days	15 Days
Response to Request for Additional Information (Member)	48 Hours	45 Days	45 Days
Extension for Internal Appeal Determination (Plan)	NONE	15 Days	15 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

9.2 DESIGNATING AN AUTHORIZED REPRESENTATIVE

You must act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. If you wish to designate an Authorized Representative, you must do so in writing. You can get a form by calling Customer Service or logging into your account at www.sanfordhealthplan.com/memberlogin. If a person is not properly designated in writing as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Policy.

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

9.3 AUDIT TRAILS

Audit trails for Complaints, Adverse Determinations and Appeals are provided by Sanford Health Plan's Information System and an Access database which includes documentation of the Complaints, Adverse Determination and/or Appeals by date, service, procedure, substance of the Complaint/Appeal (including any clinical aspects/details, and reason for the Complaint, Adverse Determination and/or Appeal.

The Appeal file includes telephone notification, and documentation indicating the date; the name of the person spoken to; the Member; the service, procedure, or admission certified; and the date of the service, procedure, or Adverse Determination and reason for determination. If Sanford Health Plan indicates authorization (Certification) by use of a number, the number will be called the "authorization number."

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9.4 DEFINITIONS

Adverse Determination: A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment (for pre-service or post-service claims) based on:

1. A determination of an individual's eligibility to participate in a plan;
2. A determination that a benefit is not a Covered Benefit;
3. The imposition of a source-of-injury exclusion, network exclusion, application of any Utilization Review, or other limitation on otherwise covered benefits;
4. A determination that a benefit is Experimental, Investigational or not Medically Necessary or appropriate; or
5. A rescission of coverage. Only an act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, made by an applicant for health insurance coverage may be used to void application or policy and deny claims.

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

Inquiry: A telephone call regarding eligibility, plan interpretation, plan policies and procedures, or plan design. It is the policy of Sanford Health Plan to address Member and Practitioner and/or Provider inquiries through informal resolution over the telephone whenever possible. If the resolution is not satisfactory to the inquirer, he or she will be instructed of his or her rights to file a verbal or written Complaint.

Complaint: An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and Practitioner and/or Provider Complaints. A process has been established for Members (or their designees) and Practitioners and/or Providers to use when they are dissatisfied with Sanford Health Plan, its Practitioners and/or Providers, or processes. Examples of Complaints are eligibility issues; coverage denials, cancellations, or non-renewals of coverage; administrative operations; discrimination based on race, color, national origin, sex, age, or disability; and the quality, timeliness, and appropriateness of health care services provided.

Complainant: This is a Member, applicant, or former Member or anyone acting on behalf of a Member, applicant, or former Member, who submits a Complaint. The Member and his/her legal guardian may designate in writing to Sanford Health Plan an Authorized Representative to act on his/her behalf. This written designation of representation from the Member should accompany the Complaint.

External Review: An External Review is a request for an Independent, External Review of a medical necessity final determination made by Sanford Health Plan through its External Appeals process.

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

a. Seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgment; or
b. In the opinion of a Practitioner with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

In determining whether a request is "Urgent," Sanford Health Plan shall apply the judgment of a Prudent Layperson as defined in Section 10. A Practitioner, with knowledge of the Member's medical condition, who

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determines a request to be "Urgent," as defined in Section 8, shall have such a request treated as an Urgent Care Request by Sanford Health Plan.

9.5 COMPLAINT (GRIEVANCE) PROCEDURES

A Member has the right to file a Complaint either by telephone or in writing to The Appeals and Grievances Department. The Appeals and Grievances Department will make every effort to investigate and resolve all Complaints. Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances Department.

9.6 ORAL COMPLAINTS

A complainant may orally submit a Complaint to Customer Service. If the oral Complaint is not resolved to the complainant's satisfaction within ten (10) business days of receipt of the Complaint, Sanford Health Plan will provide a Complaint form to the complainant, which must be completed and returned to the Appeals and Grievances Department for further consideration. Upon request, Customer Service will provide assistance in submitting the Complaint form.

9.7 WRITTEN COMPLAINTS

A complainant can seek further review of a Complaint not resolved by phone by submitting a written Complaint form. A Member, or his/her Authorized Representative may send the completed Complaint form, including comments, documents, records and other information relating to the Complaint, the reasons they believe they are entitled to benefits and any other supporting documents. Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances Department.

Complaints based on discrimination must be sent to the attention of the Section 504 Coordinator.

The Appeals and Grievances Department will notify the complainant within ten (10) business days upon receipt of the Complaint form, unless the Complaint has been resolved to the complainant's satisfaction within those **ten (10) business days**.

Upon request and at no charge, the complainant will be given reasonable access to and copies of all documents, records and other information relevant to the Complaint.

9.8 COMPLAINT INVESTIGATIONS

The Appeals and Grievances Department will investigate and review the Complaint and notify the complainant of Sanford Health Plan's decision in accordance with the following timelines:

- A decision and written notification on the Complaint will be made to the complainant, his or her Practitioners and/or Providers involved in the provision of the service within thirty (30) calendar days from the date Sanford Health Plan receives your request.
- In certain circumstances, the time period may be extended by up to fourteen (14) days upon agreement. In such cases, Sanford Health Plan will notify the complainant in advance, of the reasons for the extension.

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Any complaints related to the quality of care received are subject to practitioner review. If the complaint is related to an urgent clinical matter, it will be handled in an expedited manner, and a response will be provided within twenty-four (24) hours.

If the complaint is not resolved to the Member's satisfaction, the Member, or his/her Authorized Representative, has the right to Appeal any Adverse Determination made by Sanford Health Plan. Appeal Rights may be requested by calling the Appeals and Grievances Department.

Sanford Health Plan will make appropriate arrangements to ensure that individuals with disabilities and individuals with limited English proficiency are provided auxiliary aids and services or language assistance services, respectively, if needed to participate in the complaint or appeals process.

All notifications described above will comply with applicable law. A complete description of your Appeal rights and the Appeal process will be included in your written response.

9.9 APPEAL PROCEDURES

Types of Appeals

Types of appeals include:

- **A Pre-service Appeal** is a request to change an Adverse Determination that Sanford Health Plan approved in whole or in part in advance of the Member obtaining care or services.
- **A Post-service Appeal** is a request to change an Adverse Determination for care or services already received by the Member.
- An **Expedited Appeal** for Urgent Care is a request to change a previous Adverse Determination made by Sanford Health Plan for an Urgent Care Request. If the Member's situation meets the definition of urgent, their review will generally be conducted within 24 hours.

9.10 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.

9.11 INTERNAL APPEALS OF ADVERSE DETERMINATION (DENIAL)

Appeals can be made for up to 180 days from notification of the Adverse Determination.

Within one-hundred-eighty (180) days after the date of receipt of a notice of an Adverse Determination sent to a Member or the Member's Authorized Representative (as designated in writing by the Member), the Member or their Authorized Representative may file an Appeal with Sanford Health Plan requesting a review of the Adverse Determination. An Appeal Filing Form may be found on the Member's online account at www.sanfordhealthplan.com/memberlogin.

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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). Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances Department.

9.12 APPEAL RIGHTS AND PROCEDURES

If the Member or their Authorized Representative (as designated in writing by the Member) files an Appeal for an Adverse Determination, the following Appeal Rights apply:

- The Member shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. Members do not have the right to attend or have a representative attend the review.
- The Member shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by, or at the direction of, Sanford Health Plan in connection with the claim; and such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is required to be provided to give the Member a reasonable opportunity to respond prior to that date.
- Confirm with the Member whether additional information will be provided for appeal review. Sanford Health Plan will document if additional information is provided or no new information is provided for appeal review.
- Before Sanford Health Plan can issue a final Adverse Determination based on a new or additional rationale, the Member will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Determination is required to be provided and give the Member a reasonable opportunity to respond prior to the date. Members shall have the right to review all evidence and present evidence and testimony.
- The Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Member's initial request.
- The review shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
- Full and thorough investigation of the substance of the Appeal, including any aspects of clinical care involved, will be coordinated by the Appeals and Grievances Department.
- Sanford Health Plan will document the substance of the Appeal, including but not limited to, the Member's reason for appealing the previous decision and additional clinical or other information provided with the appeal request. Sanford Health Plan will also document any actions taken, including but not limited to, previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal.
- The review shall not afford deference to the initial Adverse Determination and shall be conducted by a Sanford Health Plan representative who is neither the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of any Adverse Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational, or not Medically Necessary or appropriate, Sanford Health Plan shall consult with a health care professional (same-or-similar specialist) who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care Practitioner and/or Provider engaged for purposes of a consultation under this paragraph shall be an individual who is neither an individual who was

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consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.
- Sanford Health Plan shall identify the medical or vocational experts whose advice was obtained on behalf of Sanford Health Plan in connection with a Member's Adverse Determination, without regard to whether the advice was relied upon in making the benefit request determination.
- In order to ensure the independence and impartiality of the persons involved in making claims determinations and appeals decisions, all decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.
- The attending Practitioner and/or Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Appeal within three (3) working days of receipt of the Appeal.
- Sanford Health Plan will provide notice of any Adverse Determination in a manner consistent with applicable federal regulations.

9.13 APPEAL NOTIFICATION TIMELINES

For Prospective (Pre-service) Appeals: for decisions not regarding pharmacy service, certification of non-covered medication, or Formulary design issues, Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within **thirty (30) calendar days** of receipt of the Appeal.

For Retrospective (Post-service) Appeals: for decisions not regarding pharmacy service, certification of non-covered medication, or Formulary design issues, Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within **sixty (60) calendar days** of receipt of the Appeal.

For Appeals Based on Discrimination: Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing within **thirty (30) calendar days** of receipt of the Appeal.

If the Member does not receive the decision within the time periods stated above, the Member may be entitled to file a request for External Review.

9.14 EXPEDITED INTERNAL APPEAL PROCEDURE

An Expedited Appeal procedure is used when the Member's condition is emergent or urgent in nature, as defined in this Certificate. An Expedited Appeal of a Prior Authorization (Pre-service) Denial must be utilized if the Practitioner acting on behalf of the Member believes that the request is warranted. This can be done by oral or written notification to Sanford Health Plan. We will accept all necessary information (electronic or by telephone) for review from the Practitioner of care. A designated Physician advisor will conduct the review and will be available to discuss the case with the attending Practitioner on request. For Medical Necessity reviews only, a Practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the request.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the Appeal via telephone by the Utilization Management Department as expeditiously as the Member's medical

condition requires but no later than within *seventy-two (72) hours* of receipt of the request. The Member and those Practitioners and/or Providers involved in the Appeal will receive written notification within *three (3) calendar days* of the telephone notification.

If the Expedited Review is a Concurrent Review determination, the service will be continued without liability to the Member until the Member or the Representative has been notified of the determination.

NOTE: For procedures, rights, and notification timelines related to an Appeal of Adverse Determination regarding pharmacy services, certification of a non-covered medication, or Formulary design issues, see External Procedures for Adverse Determinations of Pharmaceutical Exception Requests in this Section.

9.15 WRITTEN NOTIFICATION PROCESS FOR INTERNAL APPEALS

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

1. The results and date of the Appeal Determination;
2. The specific reason for the Adverse Determination in easily understandable language;
3. The titles and qualifications, including specialty, of the person or persons participating in the first level review process (Reviewer names are available upon request);
4. Reference to the evidence, benefit provision, guideline, protocol and/or other similar criterion on which the determination was based and notification that the Member on request can have a copy of the actual benefit provisions, guidelines, protocols and other similar criterion free of charge;
5. Notification the Member can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Member's benefit request;
6. Statement of the reviewer's understanding of the Member's Appeal;
7. The Reviewer's decision in clear terms and The Contract basis or medical rationale in sufficient detail for the Member to respond further;
8. Notification and instructions on how the Practitioner and/or Provider can contact the Physician or appropriate specialist to discuss the determination;
9. If the Adverse Determination is based on Medical Necessity or Experimental or Investigational Service or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the Certificate of Coverage to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
10. If applicable, instructions for requesting:
    a. A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Determination; or
    b. The written statement of the scientific or clinical rationale for the determination;
11. For Adverse Determinations of Prospective (Pre-service) or Retrospective (Post-service) Review a statement indicating:
    a. The written procedures governing the standard internal review, including any required timeframe for the review; and
    b. The Member's right to bring a civil action in a court of competent jurisdiction;
    c. Notice of the Member's right to contact the North Dakota Insurance Department for assistance at any time.
    d. Notice of the right to initiate the External Review process for Adverse Determinations based on Medical Necessity. Refer to "Independent, External Review of Final Determinations" in this Section for details on this process. Final Adverse Determination letters will contain information

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on the circumstances under which Appeals are eligible for External Review and information on how the Member can seek further information about these rights.

e. If the Adverse Determination is completely overturned, the decision notice will state the decision and the date.

9.16 EXTERNAL PROCEDURES FOR ADVERSE DETERMINATIONS OF PHARMACEUTICAL EXCEPTION REQUESTS

Sanford Health Plan follows all requirements for denials and appeals as it relates to any Adverse Determination when there has been a Medical Necessity determination based on pharmacy service, certification of non-covered medication or Formulary design issue. This applies to requests for coverage of non-covered medications, generic substitution, therapeutic interchanges and step-therapy protocols.

External Exception Review (Appeal) of a Standard Exception Request:

- If we deny a request for a Standard Exception, the Member may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization.
- The Plan will make its determination on the External Exception Request and notify the Member or the Member's Authorized Representative, and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following the Plan's receipt of the request if the original request was a Standard Exception Request.
- If the Plan grants an External Exception Review of a Standard Exception Request, the Plan will provide coverage of the non-Formulary drug for the duration of the prescription.

External Exception Review (Appeal) of an Expedited (Urgent) Exception Request:

- If Sanford Health Plan denies a request for an Expedited Exception, the Member may request that the original exception request and subsequent denial of such request be reviewed by an Independent Review Organization.
- Sanford Health Plan will make its determination on the External Exception Request and notify the Member or the Member's Authorized Representative, and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours following our receipt of the request if the original request as an expedited exception.
- If Sanford Health Plan grants an External Exception Review of an Expedited Exception Request, we will provide coverage of the non- Formulary drug for the duration of the exigency.

9.17 STANDARD EXTERNAL REVIEW REQUEST PROCESSES & PROCEDURES

1. The Plan will follow the procedure for providing independent, external review of final determinations as outlined by federal regulations and rules governing the Plan in the Patient Protection and Affordable Care Act. Accordingly, an Independent External Review is not available for a Benefit Denial when it does not involve medical judgment.

2. NOTE: Adverse Benefit Determinations, e.g. denials that do not involve medical/clinical review, are not eligible for an External Review. The Plan's decision on Benefit Determinations is final and binding. In the event of an Adverse Determination for services protected under the No Surprises Act, a Member has the right and obligation to file an Appeal with Sanford Health Plan requesting review of the Adverse Determination to determine if Surprise Billing protections are applicable.

External Appeal Review Program – OVERVIEW

Members may file a request for External Review with Sanford Health Plan or with the North Dakota Insurance Commissioner. Refer to the Introduction section at the beginning of this document for contact information.

An expedited Appeal procedure is used when the condition is an Urgent Care Situation, as defined previously in this Certificate of Coverage.

An expedited review involving Urgent Care Requests for Adverse Determinations of Pre-service or Concurrent claims must be utilized if the Member or Practitioner and/or Provider acting on behalf of the Member believe that an expedited determination is warranted. All of the procedures of a standard review described apply. In addition, for an Expedited Appeal, the request for an expedited review may be submitted. This can be done orally or in writing and the Plan will accept all necessary information by telephone or electronically. In such situations, the Practitioner who made the initial Adverse Determination may review the appeal and overturn the previous decision.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the appeal via oral notification by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than twenty-four (24) hours of receipt of the request. Sanford Health Plan will notify you orally by telephone or in writing by facsimile or via other expedient means. The Member and those Practitioners and/or Providers involved in the appeal will receive written notification within three (3) calendar days of the oral notification. If your claim is no longer considered urgent, it will be handled in the same manner as a Non-urgent Pre-service or a Non-urgent post-service appeal, depending upon the circumstances.

If the expedited review is a Concurrent Review determination, the service must be continued without liability to the Member until the Member or the representative has been notified of the determination.

9.18 EXTERNAL APPEAL REVIEW PROGRAM PROCEDURES

For independent, External Review of a final Adverse Determination, Sanford Health Plan will provide:

1. Members the right to an independent, third party, binding review whenever they meet the following eligibility criteria:

    a) The Member is Appealing an Adverse Determination that is based on Medical Necessity (benefits Adverse Determinations are not eligible);

    b) Sanford Health Plan has completed the internal Appeal review and its decision is unfavorable to the Member, or has exceeded the time limit for making a decision, or Sanford Health Plan has elected to bypass the available internal level of Appeal with the Member's permission;

    c) The request for independent, External Review is filed within four (4) months of the date that Sanford Health Plan's Adverse Determination was made.

2. Notification to Members about the independent, External Review program and decision are as follows:
    a) General communications to Members, at least annually, to announce the availability of the right to

independent, External Review.

b) Letters informing Members and Practitioners of the upholding of an Adverse Determination covered by this standard including notice of the independent, External Appeal rights, directions on how to use the process, contact information for the independent, External Review organization, and a statement that the Member does not bear any costs of the independent, External Review organization, unless otherwise required by state law.

3. The External Review organization will communicate its decision in clear terms in writing to the Member and Sanford Health Plan. The decision will include:

   a) a general description of the reason for the request for external review;
   b) the date the independent review organization received the assignment from Sanford Health Plan to conduct the external review;
   c) the date the external review was conducted;
   d) the date of its decision;
   e) the date the external review was conducted;
   f) the date of its decision;
   g) the principal reason(s) for the decision, including any, Medical Necessity rationale or evidence-based standards that were a basis for its decision; and
   h) the list of titles and qualifications, including specialty, of individuals participating in the appeal review, statement of the reviewer's understanding of the pertinent facts of the appeal and reference to evidence or documentation used as a basis for the decision.
   i) The External Review organization must also notify the Member how and when Members receive any payment or service in the case of overturned Adverse Determinations.

4. Conduct of the External Appeal Review program as follows:

   a) 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:
   b) The Member is or was a covered person at the time the health care service was requested or, in the case of a Retrospective Review, was a covered person in the Plan at the time the health care service was provided;
   c) The health care service that is the subject of the Adverse Determination is a covered service under the Member's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness;
   d) The Member has exhausted Sanford Health Plan's internal Appeal process unless the Member is not required to exhaust Sanford Health Plan's internal Appeal process as defined above; and
   e) The Member has provided all the information and forms required to process an external review.

5. Within one (1) business day after completion of the preliminary review, Sanford Health Plan shall notify the Member and, if applicable, the Member's Authorized Representative in writing whether the request is complete and eligible for external review.

6. If the request is not complete, the NDID shall inform the Member and, if applicable, the Member's Authorized Representative in writing and include in the notice what information or materials are needed to make the request complete; or if the request is not eligible for external review, the NDID shall inform the Member and, if applicable, the Member's Authorized Representative in writing and include the reasons for its ineligibility. If the Independent Review Organization upheld the denial, there is no further review available under this appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

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7. If the request is complete, within one (1) business day after verifying eligibility, the NDID shall assign an independent review organization and notify in writing the Member, and, if applicable, the Member's Authorized Representative of the request's eligibility and acceptance for external review. The Member may submit in writing to the assigned Independent Review Organization within five (5) business days following the date of receipt of the notice provided by the NDID any additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after ten (10) business days.

8. Within five (5) business days after the date the NDID determines the request is eligible for external review, of receipt, the NDID shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final Adverse Determination.

9. The North Dakota Insurance Department contracts with the independent, external review organization that:
   a) is accredited by a nationally recognized private accrediting entity;
   b) conducts a thorough review, in which it considers all previously determined facts; allows the introduction of new information; considers and assesses sound medical evidence; and makes a decision that is not bound by the decisions or conclusions of Sanford Health Plan or determinations made in any prior appeal.
   c) completes their review and issues a written final decision for non-urgent appeals within forty-five (45) calendar days of the request. For clinically Urgent Care appeals, the review and decision will be made and orally communicated as expeditiously as the Member's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. Within forty-eight (48) hours after the date of providing the oral notification, the assigned independent review organization will provide written confirmation of the decision to the Member, or if applicable, the Member's Authorized Representative, and their treating Practitioner and/or Provider.
   d) has no material professional, familial or financial conflict of interest with Sanford Health Plan.

10. With the exception of exercising its rights as party to the appeal, Sanford Health Plan must not attempt to interfere with the Independent Review Organization's proceeding or appeal decision.

11. Sanford Health Plan will provide the Independent Review Organization with all relevant medical records as permitted by state law, supporting documentation used to render the decision pertaining to the Member's case (summary description of applicable issues including Sanford Health Plan's decision, criteria used and clinical reasons, utilization management criteria, communication from the Member to Sanford Health Plan regarding the appeal), and any new information related to the case that has become available since the internal appeal decision.

12. The Member is not required to bear costs of the Independent Review Organization's review, including any filing fees. However, Sanford Health Plan is not responsible for costs associated with an attorney, physician or other expert, or the costs of travel to an independent, External Review hearing.

13. The Member or his/her legal guardian may designate in writing a representative to act on his/her behalf. A Practitioner and/or Provider may not file an Appeal without explicit, written designation by the Member.

14. The Independent Review Organization's decision is final and binding to Sanford Health Plan and Sanford Health Plan implements the Independent Review Organization's decision within the timeframe specified by the Independent Review Organization. The decision is not binding to the Member, because the Member has legal rights to pursue further appeals in court if they are dissatisfied with the outcome. However, a Member may not file a subsequent request for external review involving the same Adverse Determination for which

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the Member has already received an external review decision.

15. Sanford Health Plan maintains and tracks data on each appeal case, including descriptions of the denied item(s), reasons for denial, Independent, External Review organization decisions and reasons for decisions. Sanford Health Plan uses this information in tracking and evaluating its Medical Necessity decision-making process and improving the quality of its clinical decision making procedures. This information is reported to the Medical Management Quality Committee when a case is resolved for discussion and plan of care or action.

NOTE: All notifications and procedures described in this Section, in addition to those related to both Benefit and Medical Care Determinations in Section 2, will comply with applicable law. Should a conflict exist between Plan procedures and federal regulations, federal regulations shall control.
A complete description of your Complaint (Grievance) and Appeal Rights and the Appeal process will be included in determination responses and decisions made by Sanford Health Plan. Additionally, an overview of your Complaint (Grievance) and Appeal Rights, along with an Appeal Filing Form, is included in all Explanation of Benefits (EOBs) generated by Sanford Health Plan.

9.19 EXPEDITED EXTERNAL REVIEW REQUESTS

1. A Member or the Member's Authorized Representative may request an expedited external review of an Adverse Determination if the Adverse Determination involves an Urgent Care requests for Prospective (pre-service) or Concurrent Review request for which
    a. the timeframe for completion of a standard internal review would seriously jeopardize the life or health of the Member; or would jeopardize the Member's ability to regain maximum function; or
    b. in the case of a request for Experimental or Investigational Services, the treating Provider certifies, in writing, that the requested Health Care Services or treatment would be significantly less effective if not promptly initiated.
2. The Member has the right to contact the North Dakota Insurance Commissioner for assistance at any time.
3. Immediately upon receipt of the request from the Member or the Member's Representative, the NDID shall determine whether the request is eligible for Expedited External Review. If the request is ineligible for an Expedited External Review as described in (1) above, the NDID will give notification to the Member or the Member's Representative that they may appeal to the state insurance department.
4. Upon determination that the Expedited External Review request meets the reviewability requirements, the NDID shall assign a contracted, independent review organization to conduct the expedited external review. The assigned independent review organization is not bound by any decisions or conclusions reached during Sanford Health Plan's utilization review or internal appeal process.
5. Sanford Health Plan will send all necessary documents and information considered in making the Adverse Determination to the assigned independent review organization electronically, by telephone, or facsimile or any other available expeditious method.

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6. The independent review organization will make a decision to uphold or reverse the adverse determination and provide oral notification to the Member, and, if applicable, the Member's Authorized Representative, and the treating Practitioners and/or Providers as expeditiously as the Member's medical condition or circumstances requires but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. The Member and those Practitioners and/or Providers involved in the appeal will receive written notification within forty-eight (48) hours of the oral notification.

7. At the same time a Member, or the Member's Authorized Representative, files a request for an internal Expedited Review of an Appeal involving an Adverse Determination, the Member, or the Member's Authorized Representative, may also file a request for an external Expedited External Review if the Member has a medical condition where the timeframe for completion of an expedited review would seriously jeopardize the life or health of the Member or would jeopardize their ability to regain maximum function; or if the requested health care service or treatment is an Experimental or Investigational Service and the Member's treating Practitioner and/or Provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the Adverse Determination would be significantly less effective if not promptly initiated.

8. Upon Sanford Health Plan's receipt of the independent review organization's decision to reverse the Adverse Determination, Sanford Health Plan shall immediately approve the coverage that was the subject of the Adverse Determination.

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SECTION 10
DEFINITIONS OF TERMS WE USE IN THIS CERTIFICATE OF COVERAGE

Adverse Determination	Any of the following determinations: The denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination of a Member's eligibility to participate in the Plan; Any prospective review or retrospective Utilization Review determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit; or A rescission of coverage determination.
Affordable Care Act or ACA	The Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.
Ambulatory Surgical Center	A lawfully operated, public or private establishment that: • Has an organized staff of Practitioners; • Has permanent facilities that are equipped and operated mostly for performing surgery; • Has continuous Practitioner services and Nursing Services when a Member is in the Facility; and • Does not have services for an overnight stay.
Ancillary Services	Ancillary services are services that physicians may request to help diagnose or treat a patient. Ancillary services generally fall into the categories of: • Diagnostic: assist the physician or healthcare provider in diagnosing or detecting an illness or medical condition (e.g., audiology, radiology, clinical laboratory services, pulmonary testing services). • Therapeutic: help to improve the health and well-being of the patient (e.g., speech therapy, physical therapy, occupational therapy, psychotherapy).
Approved Clinical Trial	A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following: • A federally funded or approved trial; • A clinical trial conducted under an FDA investigational new drug application; or • A drug trial that is exempt from the requirement of an FDA investigational new drug application
Authorized Representative	A person to whom a Member has given express written consent to represent the Member, a person authorized by law to provide substituted consent for a Member, a family member of the Member or the Member's treating health care professional if the Member is unable to provide consent, or a health care professional if Sanford Health Plan requires that a request for a benefit be initiated by the health care professional. For any Urgent Care Request, the term includes a health care professional with knowledge of the Member's medical condition.
Avoidable Hospital Conditions	Conditions that could reasonably have been prevented through application of evidence-based guidelines. These conditions are not present on admission, but

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	present during the course of the stay. Participating Providers are not permitted to bill Sanford Health Plan or Members for services related to Avoidable Hospital Conditions.
Calendar Year	A period of one year which starts on January 1st and ends December 31st.
Case Management	A coordinated set of activities conducted for individual Member management of chronic, serious, complicated, protracted, or other health conditions.
Certification	Certification is a determination by Sanford Health Plan that a request for a benefit has been reviewed and, based on the information provided, satisfies Sanford Health Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, and effectiveness.
Coinsurance	The percentage of charges to be paid by a Member for Covered Services after the Deductible has been met.
Concurrent Review	Concurrent Review is Utilization Review for an extension of previously approved, ongoing course of treatment over a period of time or number of treatments typically associated with Hospital Inpatient care, including care at a Residential Treatment Facility, and ongoing outpatient services, including ambulatory care.
[This] Contract or [The] Contract	The contract between Sanford Health Plan and the Member including this Certificate of Coverage (including all attachments, amendments and addenda), the applications, andall documents describing the terms of health coverage under this policy.
Copay	An amount that a Member must pay at the time the Member receives a Covered Service.
Cosmetic	Surgery, medication, or other services performed for the primary purpose of enhancing or altering physical appearance without correcting, restoring or improving physiological function, or improving an underlying condition or disease.
Cost Sharing	An amount the Member must pay for Covered Services. Cost Sharing can be in the form of a Copay, Coinsurance or Deductible.
Covered Services	Those Health Care Services for which a Member is entitled to benefits under the terms of This Contract.

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Creditable Coverage	Benefits or coverage provided under: • Medicare or Medicaid; • An employer-based health insurance plan or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a health benefit plan; • An individual health insurance policy; • Chapter 55 of Title 10, United States Code; • A medical care program of the Indian Health Service or of a tribal organization; • A state health benefits risk pool; • A health plan offered under Chapter 89 of Title 5, United States Code; • A public health plan; • A health benefit plan under §5(e) of the Peace Corps Act (22 U.S.C. 2504)(e)); • College plan; or • A short-term limited-duration policy.
Deductible	The amount that a Member must pay each Calendar Year before Sanford Health Plan will pay benefits for Covered Services
Dependent	The Spouse and any Dependent Child.
Dependent Child(ren)	A Subscriber's biological child; • A child lawfully adopted by the Subscriber or in the process of being adopted, from the date of placement; • A stepchild of the Subscriber; or • A foster child or any other child for whom the Subscriber has been granted legal custody
Eligible Dependent	Any Dependent who meets the specific eligibility requirements of the health benefit plan
Eligible Member	Any Member who meets the specific eligibility requirements of the health benefit plan
Emergency Medical Condition or Situation	Sudden and unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health in serious jeopardy.
Encounter	Any type of initiated contact between a member and provider via a qualified telehealth technology platform.
ESRD	The Federal End Stage Renal Disease program.

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Expedited Appeal	An expedited review involving Urgent Care Requests for Adverse Determinations of Prospective (Pre-service) or Concurrent Reviews will be utilized if the Member, or Practitioner and/or Provider acting on behalf of the Member, believes that an expedited determination is warranted.
Experimental or Investigational Services	Health Care Services where the Health Care Service in question either: • is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or • requires approval by any governmental authority and such approval has not been granted prior to the service being rendered.
Facility	An institution providing Health Care Services or a health care setting, including Hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, Residential Treatment Facilities, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings.
Formulary	A list of covered prescription drugs, both generic and brand name maintained by Sanford Health Plan and applicable to this Certificate of Coverage.
Health Care Services	Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease. Health Care Services may include medical evaluations, diagnosis, treatment, procedures, drug, therapies and supplies.
Hospital	A short-term, acute care, duly licensed institution that is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians. It has organized departments of medicine and/or major surgery and provides 24-hour nursing service by or under the supervision of registered nurses. The term "Hospital" specifically excludes rest homes, places that are primarily for the care of convalescents, nursing homes, skilled nursing facilities, Residential Care Facilities, custodial care homes, intermediate care facilities, health resorts, clinics, Physician's offices, private homes, Ambulatory Surgical Centers, residential or transitional living centers, or similar facilities
Hospitalization	A stay as an inpatient in a Hospital. Each "day" of Hospitalization includes a stay for which a charge is customarily made. Benefits may not be restricted in a way that is based upon the number of hours that the Member stays in the Hospital.
Iatrogenic Condition	Illness or injury because of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error.
In-Network Benefit Level	The upper level of benefits provided by Sanford Health Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Participating Practitioner and/or Provider designated by Sanford Health Plan, in its sole discretion, as part of this Certificate of Coverage's defined network.

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

In-Network Facility	A Facility (as defined above) considered "In-Network" by the terms of this Certificate of Coverage.
In-Network Pharmacy	A Pharmacy considered "In-Network" by the terms of this Certificate of Coverage.
In-Network Participating Practitioner and/or Provider	A Participating Practitioner and/or Provider that is considered "In-Network" by the terms of this Certificate of Coverage.
Intensive Outpatient Program (IOP)	Provides mental health and/or substance use disorder outpatient treatment services during which a Member remains in the program a minimum of three (3) continuous hours per day and does not remain in the program overnight. Programs may be available in the evenings or weekends.
Long-Term Residential Care	The provision of long-term diagnostic or therapeutic services (i.e., assistance or supervision in managing basic day-to-day activities and responsibilities) to Members with physical, mental health and/or substance use disorders. Care may be provided in a long-term residential environment known as a transitional living Facility; on an individual, group, and/or family basis; generally provided for persons with a lifelong disabling condition(s) that prevents independent living for an indefinite amount of time
Maintenance Care	Treatment provided to a Member whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Practitioner and/or Provider.

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

Medically Necessary or Medical Necessity	Health Care Services that are appropriate and necessary as determined by any Participating Provider, in terms or type, frequency, level, setting, and duration, according to the Member's diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must be consistent with generally accepted standards of medical practice as recognized by Sanford Health Plan, as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and • help restore or maintain the Members health; or • prevent deterioration of the Member's condition; or • prevent the reasonably likely onset of a health problem or detect an incipient problem; or • not considered Experimental or Investigative Service
Member	Any individual who is enrolled in the Plan.
Mental Health and Substance Use Disorder Services	Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD), current editions. Also referred to as behavioral health, psychiatric, chemical dependency, substance abuse, and/or addiction services.
Natural Teeth	Original teeth, which are whole, without impairment, and are not in need of the treatment provided for reasons other than dental injury; does not include prosthetic teeth, dentures, implants, or bridges.
Never Event	Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a problem in the safety and credibility of a health care Facility. Participating Providers are not permitted to bill Sanford Health Plan or Members for services related to Never Events
Non-Covered Services	Health Care Services that are not part of benefits paid for by the Plan.
Non-Participating Provider	Non-Participating Provider: A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.

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Nursing Services	Health Care Services which are provided by a registered nurse (RN), licensed practical nurse (LPN), or other licensed nurse who is: (1) acting within the scope of that person's license, (2) authorized by a Provider, and (3) not a Member of the Member's immediate family.
Open Enrollment or Open Enrollment Period	A period of time at least once a year when Eligible Members may enroll themselves and their Dependents in the Plan
Out-of-Network Benefit Level	The lower level of benefits provided by Sanford Health Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Non-Participating Practitioner and/or Provider or a Participating Practitioner and/or Provider not designated in the network as defined by the terms of this Certificate of Coverage.
Out-of-Network Participating Practitioner and/or Provider	A Participating Practitioner and/or Provider that is considered "Out-of-Network" by the terms of this Certificate of Coverage
Out-of-Pocket Maximum Amount	The total Copay, Deductible and Coinsurance Amounts for certain Covered Services that are a Member's responsibility each calendar year. When the Out-of-Pocket Maximum Amount is met, the Plan will pay 100% of the reasonable costs for Covered Services. The Out-of-Pocket Maximum Amount resets on January 1 of each calendar year. Medical and prescription drug Copay amounts apply toward the Out-of-Pocket Maximum Amount.
Participating Provider or Participating Pharmacy	A Practitioner and/or Provider who, under a contract with Sanford Health Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, directly or indirectly, from Sanford Health Plan.
Partial Hospitalization Program	Also known as day treatment; A licensed or approved day or evening outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for individuals with mental health and/or substance use disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment with such program lasting a minimum of six (6) or more continuous hours per day.
Physician	An individual licensed to practice medicine or osteopathy.
[The] Plan	The group health plan maintained by the Group.
Plan Year	A twelve (12) month period beginning on the effective date.
Post- Stabilization Services	Medically necessary services related to an emergency medical condition, to prevent the material deterioration of a condition within reasonable medical probability.
Practitioner	A professional who provides health care services. Practitioners are usually required to be licensed, as required by law. Practitioners are also Physicians.
Prospective (Pre-service) Review	Means urgent and non-urgent Utilization Review conducted prior to an admission or the provision of a health care service or a course of treatment.

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Prudent Layperson	A person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek medical treatment for an Emergency.
Preventive	Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan.
Primary Care Physician (PCP)	A Participating Provider who is an internist, family practice Physician, pediatrician, or obstetrician/gynecologist who is a Participating Practitioner and who has been chosen to be designated as a Primary Care Physician as indicated in the Provider Directory and may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Member.
Provider	An institution or organization that provides services for Members. Examples of Providers include Hospitals and home health agencies.
Qualifying Event	A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby) and gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder.
Reduced Payment Level	The lower level of benefits provided by The Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Participating or Non-Participating Provider without certification or prior-authorization when certification/prior-authorization is required.
Residential Treatment Facility	An inpatient mental health or substance use disorder treatment Facility that provides *twenty-four (24)* hour availability of qualified medical staff for psychiatric, substance abuse, and other therapeutic and clinically informed services to individuals whose immediate treatment needs require a structured *twenty-four (*24) hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, substance abuse education/counseling. Facilities must be under the direction of a board-eligible or certified psychiatrist, with appropriate staffing on-site at all times. If the Facility provides services to children and adolescents, it must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children. Hospital licensure is required if the treatment is Hospital-based. The treatment Facility must be licensed by the state in which it operates.
Retrospective (Post-service) Review	Means any review of a request for a benefit that is not a Prospective (Pre-service) Review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication of payment. Retrospective (Post-service) Review will be utilized by Sanford Health Plan to review services that have already been utilized.
Service Area	The geographic Service Area identified in this Certificate of Coverage.
Service Charge or Premium	The amount paid to Sanford Health Plan on a monthly basis for coverage for Members under this Contract.

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Special Enrollment Period	A time outside of the open enrollment period during which you and your family have a right to sign up for health coverage. In the Marketplace, you qualify for a special enrollment period 60 days following certain life events that involve a change in family status (for example, marriage or birth of a child) or loss of other health coverage. Job-based plans must provide a special enrollment period of 30 days.
Spouse	An individual who is a Subscriber's current lawful Spouse.
Stabilization	The rendering of medical services, particularly in an emergency medical condition, to prevent the material deterioration of a condition within reasonable medical probability.
Subscriber	An Eligible Member who is enrolled in the Plan. A Subscriber is also a Member.
[This] State	The State of North Dakota.
Summary of Benefits and Coverage or SBC	Attachment I of this Contract that sets forth important information on coverage and Cost Sharing.
Utilization Review	A set of formal techniques used by Sanford Health Plan to monitor and evaluate the Medical Necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Prospective (pre-service) Review, second opinion, Certification, Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review.
Urgent Care Request	Means a request for a Health Care Services or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination: 1. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or 2. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the Health Care Services or treatment that is the subject of the request.
Urgent Care Situation	A health condition that requires prompt medical attention to prevent worsening or complications but does not meet the criteria for Emergency Medical Condition or Situation. Failure to provide care within a reasonable time (generally within 24 hours) could result in increased discomfort or need for more extensive treatment but would not place the person's health in serious jeopardy.
Us/We	Refers to Sanford Health Plan
You	Refers to the Subscriber or Member, as applicable.

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ATTACHMENT I. HEALTH SAVINGS ACCOUNT (HSA) INTEGRATION AND AUTO-ENROLLMENT ACCOUNT ESTABLISHMENT

This attachment applies only to the **Sanford Simplicity $6,500x with Auto-Enrolled HSA Plan**.

The Sanford Simplicity $6,500x with Auto-Enrolled HSA Plan is integrated with a Health Savings Account (HSA). An HSA is a tax-advantaged account that allows you to set aside pre-tax dollars to cover qualified health care or medical expenses.

As part of your enrollment in the Sanford Simplicity $6,500x with Auto-Enrolled HSA Plan offered by Sanford Health Plan, you will automatically be enrolled in an HSA administered by HealthEquity. Your HSA will not become active until you opt-in and go through the set-up process with HealthEquity. The HSA is administrated and maintained by Health Equity, not by Sanford Health Plan.

The HSA is not a part of your health insurance coverage and does not modify the benefits, cost-sharing, or coverage terms of this Qualified Health Plan. To make it easier to set up your HSA, Sanford Health Plan will transmit certain personal and enrollment-related information to HealthEquity, including information necessary to identify you, establish your account, and enable access to your HSA.

This information may include, but is not limited to:

- identifying information (such as name, address, and date of birth),
- enrollment and coverage information, and
- other information reasonably necessary to establish and maintain the HSA.

This exchange of information is conducted:

- in accordance with applicable federal and state privacy and security requirements, including the Health Insurance Portability and Accountability Act (HIPAA), and
- solely for the purpose of establishing and supporting your HSA in connection with this Plan.

HealthEquity operates as an independent HSA administrator and is responsible for maintaining your HSA and protecting your information in accordance with applicable law.

HealthEquity, Inc. Contact Information:
15 W Scenic Pointe Dr., Suite 100
Draper, UT 84020, United States
Telephone: (877) 694-3942 | TTY: 711
Website: www.healthequity.com

Customer support is available by phone or through HealthEquity's online support channels.

Health Savings Account (HSA) Opt-Out Provision

Participation in an HSA is voluntary. If you do not wish to have an HSA established in connection with your Plan enrollment, you may choose not to activate your account, or may contact the HSA administrator, Health Equity, to opt-out. No contributions will be made to your HSA except as permitted under applicable law and consistent with your elections and eligibility.

Health Savings Account (HSA) Consumer Disclosure

Important Information Regarding HSAs: An HSA is an individual account that is owned by you and must be established and maintained in accordance with federal tax law. Eligibility to contribute to an HSA depends on your individual circumstances, including enrollment in a qualifying high-deductible health plan and the absence of disqualifying coverage. The HSA is separate from your health insurance coverage. While this Plan includes integrated HSA functionality, use of an HSA is not required to enroll in or maintain coverage under this Plan. This Plan's benefits, cost-sharing structure, and coverage terms are not modified by the HSA and these benefits continue to comply with all applicable Qualified Health Plan (QHP) certification requirements. You are responsible for determining your eligibility for an HSA and for complying with applicable tax rules. You may wish to consult with a tax advisor and/or the HSA administrator, HealthEquity, for additional guidance.

ATTACHMENT II. SUMMARY OF BENEFITS AND COVERAGE

This page is intentionally left blank. Your Summary of Benefits and Coverage is an attachment to this Certificate of Coverage.

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. (For purposes of this notice, the terms "insurance company" and "insurer" include health maintenance organizations (HMOs).)

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

1. Life Insurance
    a. $300,000 in death benefits
    b. $100,000 in cash surrender or withdrawal values
2. Health Insurance
    a. $500,000 for health benefit plans (see definition below)
    b. $300,000 in disability income insurance benefits
    c. $300,000 in long-term care insurance benefits
    d. $100,000 in other types of health insurance benefits
3. Annuities
    a. $250,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal 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 health benefit plans.

"Health benefit plan" is defined in North Dakota Century Code Section 26.1-38.1-02(10) and generally includes hospital or medical expense policies, contracts or certificates, or HMO subscriber contracts that provide comprehensive forms of coverage for hospitalization or medical services, but excludes policies that provide coverages for limited benefits (such as dental-only or vision-only insurance), Medicare Supplement insurance, disability income insurance, and long-term care insurance (LTCI).

Benefits provided by a long-term care (LTC) rider to a life insurance policy of annuity contract shall be considered the same type of benefits as the base life insurance policy or annuity contract to which it relates.

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, ND 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 or HMO coverage. 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.