Sanford Employee Health Plan

Summary Plan Description
for Sanford

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: (877) 652-1844 *(toll-free)*.

Help in a language other than English is also free.
Please call (800) 892-0675 *(toll-free)* to connect with us using free translation services.

Free Help in Other Languages

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

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

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

English

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

Spanish

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

German

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

Chinese

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

Karen

တၢ်ကွဲးနိၣ်ဏဝဲဏံးနူၣ်ဏိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢဏရှဒိၣ်တဖၣ်နူၣ်လီၤ.တၢ်ကွဲးနိၣ်ဏဝဲဏံးဏိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢဏရှဒိၣ်ဘၣ်ဃးဒီးနလံာ်ပတံထိၣ်မ့တမ့ၢ်တၢ်ကျၢ်ဘၢခီဖျိ Sanford Health Plan နူၣ်လီၤ.ယုကွၢ်မ့ၢ်နံၤမ့ၢ်သီဏခိၣ်သ့ၣ်လၢတၢ်ကွဲးနိၣ်ဏံၤတက့ၢ်.ဘၣ်သ့ၣ်သ့ၣ်နကဘၣ်ဟံန့ၢ်မူဒၢလၢမ့ၢ်နံၤမ့ၢ်သီလၢတၢ်ဆၢတဲာ်ဃာ်လၢနကဟ်ဃာ်နတၢ်ဏိၣ်ဆူၣ်ဏိၣ်ချ့တၣ်ကျၢၣ်ဘၢမ့တမ့ၢ်တၢ်မၤစၢၤလၢနကဘၣ်ဟ့ၣ်ဏပ့ၤနူၣ်လီၤ.နဏိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒီးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒၣ်နဲလၢတလိၣ်ဟ့ၣ်ဏပ့ၤဘၣ်နူၣ်လီၤ.ကီး 1-800-892-0675 တက့ၢ်.

Vietnamese

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

Nepali

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

Serbo-Croatian

U ovom obavještenju su sadržane važne informacije. U ovom obavještenju su sadržane važne informacije o Vašoj prijavi

ili osiguranju preko Sanford Health Plan. Pogledajte nalaze li se u ovom obavještenju neki ključni datumi. Možda ćete morati poduzeti određenje radnje u datom roku kako biste i dalje zadržali svoje osiguranje ili pomoć pri plaćanju. Imate pravo da ove informacije, kao i pomoć, dobijete besplatno na svom jeziku. Nazovite 1-800-892-0675.

Amharic
ይህ ማስታወቂያ አስፈላጊ መረጃ ይዟል። ይህ ማስታወቂያ ስለ ማመልከቻዎ ወይም የ Sanford Health Plan ሽፋን አስፈላጊ መረጃ አለው። በዚህ ማስታወቂያ ውስጥ ቁልፍ ቀኖችን ፈልጉ። የጤናን ሽፋንዎን ለመጠበቅና በአከፋፈል እርዳታ ለማግኘት በተውሰኑ የጊዜ ገደቦች እርምጃ መውሰድ ይገባዎት ይሆናል። ይህን መረጃ እንዲያገኙ እና ያለምንም ክፍያ በቋንቋዎ እርዳታ እንዲያገኙ መብት አለዎት። 1-800-892-0675 ይደውሉ።

Sudanic-Fulfulde
Anndinoore nde'e e woodi habaru kimminiiɗum. TAnndinoore nde'e e woodi habaru kimminiiɗum dow ɗereewol tefal maaɗa maaɗa malla ko yaali dow laawol Sanford Health Plan. Maanda nyalaaɗe lewru nder anndinoore nde'e. Teema a giɗeteeɗo ngaɗa goɗɗum bako goɗɗe nyalaaɗe ngam ko yaali njamu maaɗa malla walla dow njobdi. Hakke maaɗa annda habaru ngu'u e walliinde nder wolde maaɗa naa maa a yoƃii. Noddu 1-800-892-0675.

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

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

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

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

Ukrainian
Це повідомлення містить важливу інформацію. Це повідомлення містить важливу інформацію про Ваше звернення щодо страхувального покриття через Sanford Health Plan. Зверніть увагу на ключові дати, вказані у цьому повідомленні. Існує імовірність того, що Вам треба буде здійснити певні кроки у конкретні кінцеві строки для того, щоб зберегти Ваше медичне страхування або отримати фінансову допомогу. У Вас є право на отримання цієї інформації та допомоги безкоштовно на Вашій рідній мові. Дзвоніть за номером телефону 1-800-892-0675.

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

l'aide dans votre langue à aucun coût. Appelez 1-800-892-0675.

Notice

Your employer has established a self-funded employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Summary Plan Description is provided to you in accordance with the **E**mployee **R**etirement **I**ncome **S**ecurity **A**ct of 1974 (ERISA).

This document, which is called the **Summary Plan Description (hereinafter the SPD or Plan)**, describes the Medical Benefit Plan (herein called the Plan) as established and self-funded by **Sanford** (herein called the Employer or Sponsor). This Summary Plan Description serves as both the SPD and is the official benefit plan document for the employee welfare benefit plan established by the Plan Administrator.

The **Claims Administrator** shall have full, final, and complete discretion, to construe and interpret: the Summary Plan Description and related documents, procedures and/or standards, including doubtful or disputed terms; and to conduct any and all reviews of claims and appeals, denied in whole or in part. The decision of the Claims Administrator shall be final, conclusive and binding upon all parties, except with respect to enrollment and eligibility. The **Plan Administrator** shall have final authority on all enrollment and related eligibility determinations.

IMPORTANT: This is not an insured-benefit Plan. **Sanford Health Plan (SHP)** provides claims administration services to the Plan, but Sanford Health Plan does not insure the benefits described herein. The benefits described in this Summary Plan Description, as well as any attachments or amendments appended hereto, are ***self-insured*** by the Employer, who is responsible for their payment.

General Information

ERISA requires that certain information be furnished to each Employee eligible for the Plan. The following information, together with the information contained in your Summary of Benefits and Coverage (SBC), your Summary of Pharmacy Benefits/Formulary, and any amendments or material modifications, comprise the Summary Plan Description (SPD) under ERISA.

Name of Plan

The designated name of the plan is **Sanford Employee Health Plan**.

Plan Sponsor (Employer)

The name and address of the entity that established, and maintains, the Plan is:
Sanford
801 Broadway North
Fargo, ND 58102
(877) 243-1372

Plan Sponsor's Employer Identification Number

27-1218956

Plan Administrator

Sanford
801 Broadway North
Fargo, ND 58102
(877) 243-1372

Claims Administrator

Sanford Health Plan
300 Cherapa Place, Suite 201
Sioux Falls, SD 57103
(800) 752-5863 | TTY/TDD: (877) 652-1844

Plan Effective Date

January 1, 1965

Plan Year End Date

The Plan's records are maintained on a calendar year basis beginning each plan year on January 1st and ending on December 31st.

Plan Number

501

Type of Plan

The Plan is an Employee welfare benefit plan providing group medical benefits, funded from the general assets of the Plan Sponsor.

This Plan Is Not an Employment Contract

The Plan and Summary Plan Description are not to be construed as a contract for, or of, employment.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator, 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 Plan reimbursement amount, the 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 Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Amending and Terminating the Plan

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan, in whole or in part

Procedure for Amending the Plan

The Plan Sponsor reserves the right to and may amend the Plan from time to time by written instrument. You will be notified should such a change occur, in accordance with the provisions of ERISA.

Statement of Eligibility to Enroll

Employees are eligible for benefits as designated by the Plan Sponsor.

Eligibility to receive benefits under the Plan is initially determined by the Plan Sponsor. When an eligible employee meets the criteria for eligibility, an enrollment form must be completed. The Plan Sponsor has full discretion to determine eligibility for benefits. The Plan Sponsor's decision shall be final, conclusive and binding upon all parties.

Fiduciary Definitions and Duties

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Responsibilities

A fiduciary must carry out the duties and responsibilities in the interest of the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These duties must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person acting in a like capacity and familiar with such matters, would use in a similar situation;
2. In accordance with the Plan documents.

The Named Fiduciary

A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary, or continuing either the appointment or the procedures; or
2. The named fiduciary breached its fiduciary responsibility under §405(a) of ERISA.

Named Fiduciary

Sanford
801 Broadway North
Fargo, ND 58102
(877) 243-1372

Claims Administrator Is a Fiduciary

The Claims Administrator, SHP, is a Plan fiduciary for benefit claims and appeals only. As such, SHP has the final and discretionary authority to determine claims and appeals, and has the final and discretionary authority to interpret all terms of the Plan and make factual determinations necessary to make the claim and appeal determinations. The decision made by SHP on review is final and binding, subject to your right to file a lawsuit under ERISA or other applicable law. This decision-making authority is limited only by the duties imposed under ERISA. Any determination by SHP is intended to be given deference by courts to the maximum extent allowed under ERISA. In no event, however, shall SHP be responsible or liable for any benefit payments due under the Plan.

Procedure for Allocation of Responsibilities

The Plan Administrator shall use its sole discretion to determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents.

SHP, acting on behalf of the Plan Administrator, shall have full and discretionary authority to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan.

Any construction of the terms of any plan document and any determination of fact adopted by the Plan, or SHP, acting on behalf of the Plan Administrator, shall be final and legally binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review.

If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, reference herein to the Plan Administrator shall be deemed to include reference to such delegate.

Delegation of Authority

If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, reference herein to the Plan Administrator shall be deemed to include reference to such delegate.

Plan Administrator

Sanford is the Plan Sponsor and Plan Administrator. The Plan is to be administered by the Plan Administrator, and/or is designees, in accordance with the provisions of ERISA and the Plan document.

Agent for Legal Service

Sanford
801 Broadway North
Fargo, ND 58102

Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Duties of the Plan Administrator:

1. To delegate the administration of the Plan in accordance with terms established by the Plan Administrator.
2. To interpret the Plan, including the right to resolve possible ambiguities, inconsistencies or omissions, in consultation with the Claims Administrator.
3. To decide enrollment and/or eligibility disputes that may arise relative to a Participant's rights under the Plan.
4. To prescribe procedures for filing a claim forbenefits.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims and other duties as outlined in this SPD and the Service Agreement.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA §609.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Duties of the Claims Administrator as a Limited Fiduciary:

1. To administer the Plan in accordance with its terms as set by the Plan Administrator.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To follow the Plan Administrator's procedures for reviewing complaints that may arise under the Plan relative to a Participant's rights.
4. To follow the Plan Administrator's procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain Plan documents and any other record while the Plan is administered by the Claims Administrator.
6. To administer benefits, as specified in this SPD, in accordance with a medical child support order [ERISA§609].
7. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate in accordance with the Claim Administrator's limited fiduciary role stated in the Service Agreement.

Title of Employees Authorized To Receive Protected Health Information

These identified individuals will have access to the Participant's Protected Health Information only to perform the plan administrative functions the Plan Administrator provides to the Plan.

- Broker/Agent
- Controller
- President/CEO
- CFO
- Payroll & Benefits
- Senior HR Director

This includes every employee, class of employees, or other workforce person under control of the Plan Administrator who may receive the Participant's Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Benefit Plan

in the ordinary course of business. Such individuals will be subject to disciplinary action for any use or disclosure of the Participant's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan.The Plan Administrator shall promptly report any such breach, violation, or noncompliance to the Plan Administrator; will cooperate with the Plan Administrator to correct the breach, violation and noncompliance to impose appropriate disciplinary action on each employee or other workforce person causing the breach, violation, or noncompliance; and will mitigate any harmful effect of the breach, violation, or noncompliance on any Participant whose privacy may have been compromised.

Any such breach discovered by the Plan Sponsor, shall be reported to SHP within sixty (60) days of such breach.

Funding the Plan and Payment of Benefits

The cost of the Plan is funded as follows:

The level of any Employee contributions is set by the Plan Sponsor. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction, and shall be used prior to Plan sponsor funding.

Benefits are paid directly from the Plan Sponsor to SHP (which serves as a conduit to forward payment to providers). SHP, as SHP is a mere claims-paying agent of the Plan Sponsor. All reimbursements are paid out of the general assets of the employer, and there is no separate fund or account that secures the promised benefit

Individuals covered by this Plan include all Eligible Employees, and Eligible Dependents of the Plan Sponsor. This plan is *unfunded* for purposes of compliance with Title I of ERISA.

Summary Notice and Important Phone Numbers

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Summary Plan Description for group health insurance carefully. If you have any questions about the benefits as presented in the Summary Plan Description, please contact the Employer, as Plan Administrator, or use the information below to contact SHP, the Claims Administrator.

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

Table of Contents

Privacy and HIPAA Disclosure Notices

Use and Disclosure of Your Personal Health Information

As a Business Associate of the Plan, SHP has an agreement with the Plan that allows it to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA, through its role as Claims Administrator. In addition, by applying for coverage and participating in the Plan, you agree that Sanford Health Plan may obtain, use and release all records about you, and/or any Covered Dependents, that it needs to administer the Plan or to perform any functions authorized or permitted by law. You further direct all persons to release all records to us about you, and/or any Covered Dependents, that it needs in order to administer claims under the Plan.

DISCLOSURES TO THE PLAN SPONSOR

In order for your benefits to be properly administered, Sanford Health Plan needs to share your protected health information with the Plan Sponsor (your employer).

Here are the circumstances under which Sanford Health Plan may disclose your protected health information (PHI) to the Plan Sponsor:

1. SHP may inform the Plan Sponsor whether you are enrolled in the Plan.
2. SHP Plan may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from the insurer or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
3. SHP Plan may disclose your protected health information to the Plan Sponsor for Plan administrative purposes. This is because Employees of the Plan Sponsor perform some of the administrative functions necessary for the management and operation of the Plan.

Here are the restrictions that apply to the Plan Sponsor's use and disclosure of your protected health information:

1. The Plan Sponsor will only use or disclose your protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See Sanford Health Plan's Privacy Notice below for more information about permitted uses and disclosures of protected health informationunder HIPAA.
2. If the Plan discloses any of your protected health information to any of its agents or subcontractors, the Plan will require the agent or subcontractor to keep your protected health information as required by the HIPAAregulations.
3. The Plan Sponsor will not use or disclose your protected health information for employment-related actions or decisions, or in connection with any other benefit or benefit plan of the Plan Sponsor.
4. The Plan Sponsor will promptly report to SHP any use or disclosure of your protected health information that is inconsistent with the uses or disclosures provided for in this Summary Plan Description and the Service Agreement.
5. The Plan will allow you SHP to inspect and copy any protected health information about you that is in the Plan's custody and control. The HIPAAregulations set forth the rules that you and the Plan must follow in this regard. There are some exceptions.
6. The Plan will amend, or allow SHP to amend, any portion of your protected health information to the extent permitted or required under the HIPAAregulations.
7. With respect to some types of disclosures, the Plan will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The Plan does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations.
8. The Plan will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to SHP and to the U.S. Department of Health and Human Services, or its designee.
9. The Plan will, if feasible, return or destroy all of your protected health information in the Plan's custody or control that the Plan has received from SHP or from any business associate when the Plan no longer needs your protected health information to administer the Plan. If it is not feasible for the Plan to return or destroy your protected health information, the Plan will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.
10. The classes of Employees or other workforce members listed in this booklet under the control of the Plan may use or disclose your protected health information in accordance with the HIPAAregulations that have just been explained and as outlined on page iv.
    a. The Plan Sponsor's Human Resources Department, including its employees tasked with coordinating benefits, and/or other staff as appropriate, for the administration of the Plan.
11. If any of the foregoing Employees or workforce members of the Plan use or disclose your protected health information in violation of the rules that are explained above, its employees, or workforce members, will be subject to disciplinary action and sanctions - which may include termination of employment. If the Plan Sponsor becomes aware of any violation like this, the Plan Sponsor will promptly report the violation to SHP and will cooperate with it to correct the violation; impose appropriate sanctions; and mitigate any harmful effects to you.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW PERSONALHEALTH INFORMATIONABOUT YOU MAYBE USED AND DISCLOSED AND HOW YOU CAN GETACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice applies to SHP [herein known as "we"/"us"/"our"]. If you have questions about this Notice, please contact Customer Service at (800) 752-5863 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*.

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

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

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

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

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

We may contact you in the following situations:

- **Treatment options:** To provide information about treatment alternatives or other health related benefits or Plan services that may be of interest to you.
- **We will not use your information for marketing or fundraising, and will not sell your information.**

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 30 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your health and claims records:** You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we will tell you why in writing. These requests should be submitted in writing to the contact listed below.

- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be approved. We must say "yes" if you tell us you would be in danger if we do not.
- **Ask us to limit what we use or share:** You can ask us to restrict how we share your health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **Get a list of those with whom we have shared information:** You can ask for a list (accounting) of the times we have shared your health information for six (6) years prior, who we have shared it with, and why. We will include all disclosures except for those about your treatment, payment, and our health care operations, and certain other disclosures (such as those you asked us to make). We will provide one (1) accounting a year for free, but we will charge a reasonable cost-based fee if you ask for another within twelve (12) months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated:** You can complain to the U.S. Department of Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.
- **Claims Administrator Contact Information:**
  Sanford Health Plan
  PO Box 91110
  Sioux Falls, SD 57109-1110
  (800) 752-5863 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

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

CHANGES TO THIS NOTICE

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

EFFECTIVE DATE

This Notice of Privacy Practices is effective on the effective date of the Plan.

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT FOR SANFORD HEALTH PLAN

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

Introduction

Special Communication Needs

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

Translation Services

SHP can arrange for translation services. Free written materials are available in several different languages and free oral translation services are available. Call toll-free (800) 752-5863 for help and to access translation services.

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

If you are deaf or hearing impaired and need to speak to SHP, call TTY/TDD: (877) 652-1844 *(toll-free)*.

Please contact SHP toll-free at (800) 752-5863 if you are in need of a large print copy or cassette/CD of any of SHP's written materials.

Notice of Rights and Protections under ERISA

The following ERISA rights are required by federal law and regulation. As a Participant in the Plan, you are entitled to certain rights and protection under the **E**mployee **R**etirement **S**ecurity **A**ct of 1974 (ERISA).

ERISA provides that all Plan Participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

a. Examine, without charge, at the Plan Sponsor's office and at other specified locations such as worksites, all Plan documents governing the Plan, including insurance contracts, the latest Summary Plan Description, and copies of all documents filed by the Plan Sponsor, such as Form 5500 Series Summary Annual Reports (SAR) (Form 5500 Series) with the U.S. Department of Labor;

b. Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Sponsor. The administrator may make a reasonable charge for the copies; and

c. Receive a summary of the Plan Sponsor's annual financial report. The Plan Sponsor is required by law to furnish each Participant with a copy of this summary annual report.

2. Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes obligations upon the persons who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4. Enforce Your Rights

a. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. You have a right to have the Plan Sponsor review and reconsider your claim.

b. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Sponsor, and do not receive them within thirty (30) days, you may file suit in a federal court. In such case, the court may require the Plan Sponsor to provide the materials and pay up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

c. If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted SHP's claims procedures, you may file suit in court. In addition, if you disagree with SHP's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.

d. If it should happen that the Plan fiduciaries misuse the Plan Sponsor's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person or entity you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. Assistance with Your Questions

a. If you have questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement, or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Administration, U.S. Department of Labor; the contact information for your nearest office is:

Kansas City Regional Office
2300 Main St., Ste. 1100
Kansas City, MO 64108
Tel (816) 285-1800

Fax (816) 285-1888

b. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor at 200 Constitution Avenue N.W., Washington, D.C. 20210.

Fraud

Fraud is a crime that can be prosecuted. Any Participant who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud.

As a Participant, you must:

1. File accurate claims. If someone else files claims on your behalf, you should review the form before you sign it;
2. 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;
3. Never allow another person to seek medical treatment under your identity. If your ID card is lost, you should report the loss to SHP immediately; and
4. Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

If you are concerned about any of the charges that appear on a bill, Explanation of Benefits, form, or other document; or if you know of or suspect any illegal activity, call SHP toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844 *(toll-free)*. All calls are strictly confidential.

Physical Examinations

SHP, at the Plan's expense, may require a physical examination of the Participant as often as necessary during the pendency of a Claim for Benefits and may require an autopsy in case of death, if the autopsy is not prohibited by law.

Service Area

The Plan uses the network of Sanford Health Plan, as described below:

The Sanford Health Plan Service Area for **SOUTH DAKOTA** includes all counties in the State.

The Sanford Health Plan Service Area for **NORTH DAKOTA** includes all counties in the State.

The Sanford Health Plan Service Area for **IOWA** includes the following counties:

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

The Sanford Health Plan Service Area for **MINNESOTA** includes the following counties:

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

Medical Terminology

All medical terminology referenced in this Summary Plan Description follows the industry standard definitions of the American Medical Association.

Definitions

Capitalized terms are defined in this Summary Plan Description in Section 11.

Value-Added Program Disclosure

SHP may, from time to time, offer health or fitness related programs to our Participants through which Participants 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. SHP 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.

Conformity with Federal Laws and Regulations

Any provision in this SPD that is not in conformity with applicable federal laws, rules, or regulations may not be rendered invalid but is to be construed and applied as if it were in full compliance with such laws, rules, or regulations.

As federal regulations change, your coverage may also change. In such instances, you will be notified by the Plan.

Limitation Period for Filing Suit

No legal action may be brought for payment of benefits under this Benefit Plan prior to a Participant completing the administrative appeal process. A suit for benefits under this Plan must be brought within two (2) years after the expiration of the time within which notice of a Claim for Benefits is required by this Benefit Plan. See Sections 2 and 10 for applicable timelines and details on appealing an Adverse Determination.

Notice of Non-Discrimination

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

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

If you need these services, contact our Civil Rights Coordinator.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Tami Haberer, Director of Customer Service & Enrollment, 300 Cherapa Place #201, Sioux Falls, SD 57109, (605) 328-6800, TTY Number: 877-652-1844, memberservices@sanfordhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights Coordinator is available to help you.

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

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

Summary of Benefits & Coverage

Your Summary of Benefits and Coverage is available on Sanford's intranet under "Employee Benefits". Printed versions are available free of charge by contacting your local Sanford Human Resources Department.

Section 1. Enrollment

Employee Eligibility

Eligible employees include employees who customarily work twenty-four (24) or more hours per pay period and are not designated as Pro Rata Non (PRN) on the Employer's personnel records.

When an Eligible Employee meets the Plan Sponsor's criteria for eligibility, an enrollment form must be completed and processed by the Plan Administrator/Employer. The Plan Sponsor has the ultimate decision making authority regarding eligibility to enroll and become eligible for benefits.

When to Enroll

To become a Participant, an Eligible Employee must enroll within the applicable Initial Enrollment Period or any Open Enrollment Period. Open Enrollment is a period of time when Eligible Employees may enroll themselves and their Eligible Dependents in the Plan.

Late Enrollees

A "Late Enrollee" is an Eligible Employee or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage. "Late Enrollees" may not enroll at any time during the year other than during the next scheduled Open Enrollment Period. A Participant is not a "Late Enrollee" if special enrollment rights apply, as described later in this Section. If an Employee wishes to make a benefit election change after thirty (30) days from a qualified life event in which special enrollment rights apply, the employee must wait until the next annual open enrollment period.

Timely, Open, or Late Enrollment

Timely Enrollment

An enrollment will be "timely" if completed:

a. during the open enrollment period, or
b. within thirty (30) days after the person becomes eligible to enroll, in accordance with Employee/Dependent Eligibility requirements; or
c. under a Special Enrollment Period.

Open Enrollment

Prior to the start of a Coverage/Benefit Year, this Plan has an Open Enrollment Period. "Open Enrollment Period" means the period of time occurring toward the end of the Coverage Year during which:

a. Eligible Employees who are not covered under this Plan may elect to begin coverage effective the first day of the upcoming Coverage Year; and
b. Participants will be given an opportunity to change their coverage effective the first day of the upcoming Coverage Year.

The terms of the open enrollment period, including duration of the election period, shall be determined by the Plan Administrator/Sponsor and communicated prior to the start of an open enrollment period.

Late Enrollment

1. A "Late Enrollee" is an Eligible Employee or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage.
2. Late Enrollees and their Dependents who either are not eligible to join the Plan or choose not to elect coverage may only join during a subsequent open enrollment period.
3. A Participant is not a "Late Enrollee" if special enrollment rights apply, as described later in this SPD.
4. If an Employee wishes to make a benefit election change after 30 days from a qualified life event, during which special enrollment rights applied, the employee must wait until the next annual open enrollment period.
5. If an individual loses eligibility for coverage as a result of terminating employment, or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment, or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

Status of Participant Eligibility

The Plan Administrator agrees to furnish SHP with any information required by SHP for the purpose of enrollment. Any changes affecting a Participant's eligibility for coverage must be provided to SHP by the Plan Administrator and/or the Participant immediately, but in any event, the Plan Administrator and/or the Participant shall notify SHP within 30 days of the change.

Statements made in connection with Plan enrollment are deemed representations and not warranties. A Participant making a statement (including the omission of information) in connection with Plan enrollment, or in relation to any of the terms of this Benefit Plan, constituting fraud or an intentional misrepresentation of a material fact will result in the Rescission of coverage under of this Benefit Plan. A rescission is a cancellation or discontinuance of coverage, including any benefits paid, that has a retroactive effect of voiding this Benefit Plan or any benefits paid under the terms of this Benefit Plan.

How to Enroll

Both the Plan Sponsor and Participant are involved in the enrollment process.

The Participant must:

1. Complete the enrollment process, as designated by the Plan Sponsor, for the Eligible Employee and any Eligible Dependents; and
2. Provide all information needed to determine the eligibility of the Eligible Employee and/or Dependents, if requested by the Plan.

The Plan must provide all information needed by SHP to effectuate coverage.

When Coverage Begins

The effective date for coverage under the Plan is determined by the Plan Sponsor to effectuate coverage are not immediately met, the effective date of coverage may be delayed. However, this delay may not exceed thirty (30) days from the date that all coverage requirements are met.

If you are an inpatient in a Hospital or other Facility on the day your coverage begins, the Plan will pay benefits for Covered Services that you receive beginning on the date your coverage becomes effective, as long as you receive Covered Services in accordance with the terms of this SPD. Payment of benefits is subject to this Plan's Coordination of Benefit provisions and any obligations under a previous plan or coverage arrangement, in accordance with applicable regulations. For more information, see Section 6, "*Coordination of Benefits*".

USERRA Reinstatement

Special rules apply to those Eligible Employees whose coverage is reinstated following a leave of absence governed by the Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA). Under USERRA, a Covered Individual entitled to have coverage reinstated upon returning to work following a military leave of absence shall be treated as if no break in coverage occurred during the leave. For more information regarding USERRA rights, see Section 9, *Options After Coverage Ends*.

Eligibility Requirements for Dependents

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

Spouse - The Participant's legal spouse is eligible for coverage, subject to the eligibility requirements as designated by the Plan Sponsor.

1. **Common Law Spouse** – To be eligible for coverage the Participant, and their Common Law Spouse, must meet all the following requirements:
   a. Are not in a Common Law marriage relationship with anyone else;
   b. Reside in or move from a state that recognizes Common Law marriages;
   c. Share a principle residence and intend to do so permanently;
   d. Be at least eighteen (18) years of age or older and mentally competent to consent to contract;
   e. Are not blood relatives to a degree of closeness that would prohibit marriage;
   f. Are in a committed and exclusive relationship, jointly responsible for the other's welfare and financial obligations; and
   g. Agree to sign an Affidavit of Common Law Marriage upon enrollment of a common law spouse in this Benefit Plan. *A Notice of Termination of common law marriage will* be *required upon termination of the relationship with the Participant.*

Dependent Child(ren) – To be eligible for coverage, a Dependent Child must meet the following requirements:

1. Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child; and meet one of the following requirements:
   a. under age twenty-six (26); or
   b. incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Participant for support and maintenance. If the Plan so requests, the Participant must provide proof of the child's disability within *thirty* (30*)* days of the Plan's request.

Coverage extends to the end of the month in which the Dependent reaches the Plan's limiting age, as designated above. Dependent coverage does not include the spouse of an adult Dependent. Coverage does not include the child of an adult Dependent (grandchild) unless that grandchild meets other specified coverage criteria. The adult Dependent's marital status, financial dependency, residency, student status or employment status will not be considered in determining eligibility for initial or continued coverage.

NOTE: Benefits for Covered Services received Out-of-Network by Eligible Dependent Children who are residing outside the Service Area will be paid at the In-Network Benefit Level when an *Out-of-Area Waiver Form* is submitted to the Claims Administrator. Only Emergency or Urgent Care Services are payable at the In-Network benefit level. **There is no coverage for any other health care service received from a Non-Participating Practitioner and/or Provider Out-of-Network.**

NOTE: At any time, the Plan Administrator may require proof that a person qualifies, or continues to qualify, as a Dependent eligible for coverage under this Plan.

When and How to Enroll Dependents

When to Enroll Dependents

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

How to Enroll Dependents

A Eligible Employee must:

1. Complete the enrollment process, as designated by the Plan Sponsor, for the Eligible Employee and any Eligible Dependents; and
2. Provide all information needed to determine the eligibility of the Eligible Employee and/or Dependents, if requested by Plan Sponsor.

When Dependent Coverage Begins

1. General

If a Dependent is enrolled at the same time the Participant enrolls for coverage, the Dependent's effective date of coverage will be the same as the Participant's effective date. Coverage may be applied for by contacting the Benefits Enrollment Call Center. For enrollment questions, contact your local Sanford Human Resources office.

2. Delayed Effective Date of DependentCoverage

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 from a previous group health plan, or other coverage arrangement, benefits paid by this Plan shall be coordinated with the previous payor as outlined in Section 6, Coordination of Benefits.

3. Eligibility at Birth

If a Participant has a child through birth, the child will become a covered Dependent from the first of the month in which the child was born, if that coverage is applied for within thirty (30) days from the date of birth, and the required Premium payments are paid.

A newborn Child of a Participant is not automatically enrolled in this Plan, even if the Participant has previously elected coverage for other dependents. Participant must affirmatively enroll the newborn child. Charges for care immediately upon delivery for a newborn child will be covered under the Mother's benefit plan.

If the newborn child is not enrolled under this Plan within thirty (30) days of birth, there will be no payment by the Plan of charges attributable to the child after the mother's discharge. In such a case, subsequent enrollment of the child will be subject to "Late Enrollee" provisions as described in this SPD.

An Eligible Employee, and/or any other Dependent(s) eligible to be enrolled in the Plan, but who failed to enroll during a previous enrollment period, shall be covered under this Plan from the first of the month in which the new child was born, provided that the enrollment process is done within thirty (30) days from the date of the newborn's birth and the required Premium payments are paid.

Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for coverage under the Plan, provided coverage is applied for the Spouse and, if applicable, the Participant, within thirty (30) days of the newborn's birth and the required Premium payments are paid.

4. Adoption or Children Placed for Adoption

If a Participant adopts a child, or has a child placed with him or her as a Dependent, that child will become covered as a legal Dependent from the first of the month in which the earlier of the following occur: 1) the date of adoption; or 2) beginning of the six (6) month adoption bonding period, as noted in the legal adoption papers; and provided that the enrollment process is done for the child within thirty (30) days from either 1) the date of adoption; or 2) the beginning of the six (6) month adoption bonding period and the required Premium payments are paid.

An Eligible Employee, and any other Dependent(s) eligible to be enrolled in the Plan, but who failed to enroll during a previous enrollment period, shall be covered from the first of the month in which either of the following occur: 1) the date of adoption; or 2) the beginning of the six (6) month adoption bonding period, as noted in the legal adoption papers; and provided that coverage is applied for within thirty (30) days of either 1) the date of adoption; or 2) the beginning of the six (6) month adoption bonding period, and the required Premium payments are paid.

Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for coverage under the Plan, provided that coverage is applied for the Spouse and, if applicable, the Participant, within thirty (30) days of either 1) the date of adoption; or 2) the beginning of the six (6) month adoption bonding period, and the required Premium payments are paid.

Coverage at the time of placement for adoption includes the necessary care and treatment of medical conditions existing prior to the date of placement.

5. New Spouses and DependentChildren

If a Participant gets married, his or her Spouse, any of the Participant's Eligible Dependents, and any of the Spouse's Dependents, who become Eligible Dependents of the as a result of the marriage, will become covered as a Participant(s) from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for within thirty (30) days of the date of marriage and the required Premium payments are paid.

If an Eligible Employee who does not currently have coverage under the Plan gets married, the Eligible Employee, his or her Spouse, any of the Employee's Eligible Dependents, and any of the Spouse's Dependents who become Eligible Dependents of the Eligible Employee as a result of the marriage, will become covered as Participant(s) from the first day of the calendar month beginning after the date of marriage, provided that Eligibility requirements for a Dependent, listed previously in this Section 1, and coverage is applied for the Eligible Employee, and any Dependents, within thirty (30) days of the date of marriage and the required Premium payments are paid.

Limitations on Qualifying for Coverage

The following are not Covered Individuals under the Plan:

1. Other individuals living in the Participant's home, but do not meet the requirements for a Dependent as previously described; or
2. The legally separated or divorced former Spouse of the Participant.

Additionally:

1. If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during, and after the change in status, credit will be given for all Cost-Sharing Amounts.
2. If both mother and father are Participants, any children will be covered as Dependents of the mother or father, but not of both.
3. The Plan does not cover, as a Dependent, any person who is enrolled as an Eligible Employee.
4. If two Eligible Employees are married to each other, they may each enroll as Eligible Employees, or one of them may enroll as an Eligible Employee and the other as a Dependent of the enrolled Employee. However, one individual cannot be enrolled as both an Eligible Employee and a Dependent under this Plan.

Noncustodial Participants and Dependent Child(ren)

Whenever a Dependent Child receives coverage under the Plan through the noncustodial parent, who is the Participant, the 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 the Plan;
2. Allow the custodial parent, or a Provider/Practitioner, with the custodial parent's approval, to submit claims for Covered Services rendered to the Dependent Child(ren) without approval from the noncustodial parent; and
3. Make payment on claims for covered services submitted directly by the custodial parent or Provider/Practitioner.

Qualified Medical Child Support Order (QMCSO) Provision

Purpose

The Employee Retirement Income Security Act of 1974 (ERISA) and the Child Support Performance and Incentive Act of 1998 (CSPIA) require the Employer to take certain actions to help enforce state administrative and court orders for medical child support.

The Plan Sponsor, pursuant to the ERISA §609(a), adopts the following procedures for determining whether Medical Child Support Orders are qualified in accordance with the ERISA's requirements. Sanford also adopts these procedures to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required. Sanford reserves the right to alter, amend, or terminate these procedures, and substitute alternative procedures to satisfy legal requirements.

NOTE: A state administrative order issued under CSPIA automatically is deemed qualified.

Definitions

For purposes of the QMCSO requirements, the following terms have these meanings:

1. **Alternate Recipient** means any child of a Participant who is recognized under a Medical Child Support order as having a right to enroll in a group health plan with respect to the Participant.
2. **Medical Child Support Order** means any court judgment, decree or order (including approval of settlement agreement) or state administrative order that:
   a. Provides child support for a child of a Participant under the group health plan; or
   b. Provides for health coverage to such a child under state domestic relations law (including a community property law); and
   c. Relates to benefits under this Plan.
3. **Plan** means the employee medical benefit plan, including all supplements and amendments in effect.
4. **Qualified Medical Child Support Order** means a Medical Child Support Order of a court or administrative tribunal that creates or recognizes an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a participant or Beneficiary is eligible under a group health plan, and which Sanford has determined meets the qualification requirements of these procedures.
5. To be Qualified, a Medical Child Support Order must clearly:
   a. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order;
   b. Include a reasonable description of the type of coverage to be provided by SHP to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
   c. Specify each period to which such order applies

   Furthermore, to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements described in §1908 of the Social Security Act (relating to enforcement of child support and reimbursement to Medicaid).
6. Any terms used in these QMCSO procedures and defined in the Plan shall have the meaning assigned to such term under the Plan.

Procedures

Upon receipt of a Medical Child Support Order, the Plan Sponsor shall:

1. Promptly notify in writing the Participant, each Alternate Recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order, and these QMCSO procedures for determining whether such order is a QMCSO.
2. Permit the Alternate Recipient to designate a representative to receive copies of notices sent to the Alternate Recipient regarding the Medical Child Support Order.

3. Within a reasonable period after receiving a Medical Child Support Order, determine whether it is a Qualified Order and notify the parties as indicated in No.1 above of such determination.
4. Ensure the Alternate Recipient is treated by the Plan as a Beneficiary for ERISA reporting and disclosure purposes; e.g. by distributing to the Alternate Recipient a copy of the Summary Plan Description, Summary of Benefits and Coverage (SBC), Summary of Pharmacy Benefits/Formulary, and any benefit plan changes, as specified in any Summary of Material Modification.

If SHP receives a state administrative or court Medical Child Support Order under CSPIA, requiring the Company to withhold Employee contributions for group health coverage for a Child, the Plan Sponsor will determine whether the Employee is covered or eligible under the Plan, and whether the child is eligible under the Plan.

After the Plan Sponsor or Plan Administrator determines that the Employee is subject to income withholdings to pay for the child's coverage, the Plan Sponsor/Administrator will then notify the Employee, the child and the child's custodial parent (when that is not the Employee) that coverage is or will become available. The Plan Administrator will furnish the custodial parent, or legal representative of the Dependent child a description of the coverage available, the effective date of the coverage and any forms, documents or other information needed to put the coverage into effect, as well as information needed to submit claims for benefits.

The Plan Administrator/Sponsor will determine whether Employee contributions are available to pay for the child(ren)'s coverage. If such funds are available, the Employer will withhold contributions from Employee income and notify the Employee to that effect.

Special Enrollment Rights

Special enrollment rights may apply when an Employee experiences a life-changing event that qualifies them to make mid-year changes to benefit elections. Qualified Life Events are changes in an Employee's and/or an Employee's Dependent's life that affect benefit eligibility and coverage availability under the Plan.

Special enrollment rights for a qualified life event also apply when an individual becomes an Employee's Dependent through marriage, birth, adoption, or placement for adoption; or when an Employee or Eligible Dependent loses other health coverage.

To enroll an Eligible Employee's new Dependent(s) under a special enrollment period, the Plan will also require the Eligible Employee to enroll. Special enrollment rights extend to all benefit packages available under the Plan.

NOTE: For qualified life events allowing special enrollment rights, Employees must contact their Human Resources – Benefits Department within thirty (30) days of the life event. Requests for Special Enrollment must be received by the Plan no later than thirty (30) days after the date of exhaustion or termination of coverage.

NOTE: If an Employee wishes to make benefit election changes after the first thirty (30) days from a qualified life event, the Employee must wait until the next annual open enrollment period.

Qualified Life Events, in accordance with IRS Regulations, include:

- The birth or adoption of a child, or your child's placement for adoption.
- Your marriage, legal separation, divorce, or annulment.
- The termination or beginning of your spouse's or your dependent's employment.
- You, your spouse's or your dependent's job status changes from full-time to part-time or from part-time to full-time.
- A significant change in your or your spouse's coverage due to your spouse's employment.
- Eligibility for your dependent begins or ends.
- A change in residence or work site for you, your spouse, or your dependent.
- The death of your spouse or dependent.
- Commencement or return from an unpaid leave of absence.
- Become eligible or lose eligibility for Medicaid or State Children's Health Insurance Program (SCHIP) - you have 60 days from the effective date.
- Become eligible or lose eligibility under the Federal Employee Health Benefits (FEHB) program.

Any Eligible Employee or Eligible Dependent who was not previously enrolled in the Plan and has lost prior coverage may be able to enroll in the Plan within thirty (30**) days after the date of exhaustion of the previous coverage** provided that any of the following conditions are met:

1. **Waived Coverage**. The Eligible Employee and/or Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage was initially (upon date of hire) offered to the Eligible Employee or Eligible Dependent; or, after subsequently enrolling in other coverage, the Eligible Employee had an opportunity to enroll during the open enrollment period or at the time of a special enrollment period, but again chose not to enroll; and the Eligible Employee stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment (applicable only if the Plan Sponsor required such a statement at such time and provided the individual with notice of such requirement at such time);*
    a. The Eligible Employee stated in writing when enrollment was available under this Plan, that coverage under a group health plan or other health insurance coverage was the reason for declining enrollment; *
1. **Exhausted COBRA**. The Eligible Employee or Eligible Dependent had previous coverage under a COBRA or state continuation provision and the coverage under such provision has now been exhausted;**

2. **Change in Employer Eligibility Rules or Employer Contributions**. The Participant's previous coverage was not under COBRA, and coverage was terminated as a result of loss of eligibility for coverage, terminated for a class of similarly situated individuals, or terminated because employer contributions toward such coverage ended;
3. **A Move out of SHP's Service Area**. The Participant's previous coverage was terminated because the Participant no longer resides, lives or works in SHP's Service Area and the Plan does not provide coverage for that reason.
4. **Cessation of Dependent status**. The Participant attains an age in excess of the maximum age for coverage as a Dependent child.

Requests for Special Enrollment must be received by the Plan not later than thirty-one (31) days after the date of exhaustion or termination of coverage.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace at www.healthcare.gov. You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace.

** Loss of Minimum Essential Coverage due to failure to make premium payment and/or allowable rescissions of coverage does not qualify for special enrollment*

*** Voluntarily terminating/dropping COBRA coverage before it runs out outside Open Enrollment, does not qualify for a special enrollment period. COBRA coverage must be exhausted (usually 18 or 36 months) or another qualifying life event must occur before eligible for special enrollment.* ***Losing COBRA coverage due to non-payment of premiums will not result in rights to a special enrollment period.***

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 grants Special Enrollment Rights to Employees and dependents who are eligible for, but not enrolled in, a group health plan to enroll in the Plan upon:

- losing eligibility for coverage under a state Medicaid or CHIP program; or
- becoming eligible for state premium assistance under Medicaid or CHIP.

In order to qualify for Special Enrollment, an Eligible Employee or Dependent must request coverage within sixty (60) days of either being: 1) terminated from Medicaid or CHIP coverage; or 2) determined to be eligible for premium assistance. The Plan will also require the Eligible Employee to enroll. Special enrollment rights extend to all benefit packages available under the Plan. If you have questions about enrolling in your employer plan under CHIPRA Special Enrollment Rights, contact the Department of Labor at www.askebsa.dol.gov or call (866) 444-3272 *(toll-free)*.

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

Section 2. How you get care

Identification cards

SHP will send you an identification (ID) card when you enroll. You must show it whenever you receive services from a Provider, a health care facility, or fill a prescription at an In-Network Plan pharmacy. If you fail to show your ID card at the time you receive health care services or prescription drugs, you will be responsible for payment of the claim after the In-Network Participating Practitioner and/or Provider's timely filing period of one-hundred-eighty (180) 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*)* days after the effective date of your enrollment, or if you need replacement cards, call us at (800) 752-5863 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)* or write to Sanford Health Plan at PO Box 91110, Sioux Falls, SD, 57109-1110. You may also request replacement cards by signing into your account at www.sanfordhealthplan.com/memberlogin. Information on creating an account is available at www.sanfordhealthplan.com/memberlogin.

Conditions for Coverage

This Plan does not pay all medical expenses. It pays certain expenses under certain circumstances.

Participants shall be entitled to coverage for the Health Care Services (See "*Covered Services*" in Section 3) **that are :**

1. Medically Necessary, and/or Preventive, services within the scope of health care benefits covered by this Plan received from or provided under the orders or direction of an In-Network Participating Practitioner and/or Provider: or
2. Services otherwise authorized by Sanford HealthPlan.

However, this specific condition does not apply to Emergency Condition, as defined in Section 11. In such cases, Emergency or Urgent Care services will be covered if they are provided by a Non-Participating Provider or an Out-of-Network Participating Provider. Services must meet Prudent Layperson definitions, as described later in this Summary Plan Document.

If during an Emergency Condition, the Participant is in the Plan's Service Area and is alert, oriented and able to communicate (as documented in medical records), the Participant must direct the ambulance to the nearest In-Network Participating Practitioner and/or Provider.
The Covered Individual must pay any applicable Cost-Sharing Amounts.

NOTE: Just because a Health Care Provider recommends, or prescribes, a course of treatment does not mean that the Plan will pay the cost.

Designating a Provider and/or Practitioner

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

Participants have the right to designate any PCP who participates in the Plan network and who is available to accept the Participant. For information on how to select a PCP, and for a list of the Participating PCP's, contact Customer Service toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844 *(toll-free)* or visit www.sanfordhealthplan.com. For children, you may designate a pediatrician as their PCP. Participants who are female do not need prior authorization from the Plan, or from any other person (including a PCP), in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Customer Service at toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844 *(toll-free)* or visit www.sanfordhealthplan.com.

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 this SPD; your Summary of Benefits and Coverage, and/or your Summary of Pharmacy Benefits.

In-Network Coverage

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

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

NOTE: This Plan does not cover most Out-of-Network services. *For Out-of-Network coverage, please see Section 3(g).*

In-Network Coverage means Covered Services that are received:

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

NOTE: If you choose to go to a Non-Participating Practitioner and/or Provider or an Out-of-Network Participating Practitioner and/or Provider when access to an In-Networking Participating Practitioner and/or Provider is available, your claims will be denied and you will be responsible for all charges.

Provider Access

Participants who live outside of SHP's Service Area must use SHP's contracted Network of Participating Practitioners and/or Providers as indicated on the *Participant Welcome Letter* attached to the Member Identification Card. Participants 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 a Participant chooses to go to either an Out-Of-Network Provider or a Non-Participating Practitioner or Provider when appropriate access is available, the services will be will be denied and you will be responsible for all charges.

Transplant Services
Transplant Services must be performed at designated Plan Participating *Centers of Excellence*. 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 the Plan's transplant policy.

Pharmacy/Prescription Drug Services
Prescription medications, drugs, and/or devices must be dispensed by an In-Network Pharmacy Provider. There is no coverage for these services received Out-of-Network. For benefit details, see Section 3(e) and/or your SBC.

Participant Process for Seeking Urgent/Emergency (Urgent Pre-service) Medical Care

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.

Emergency admissions to a hospital do not require you to file a pre-service claim so long as you provide notice to us within forty-eight (48) hours of the admission and we certify the admission as both medically necessary and as an emergency admission. Additionally, because of the inability to predict admission, obstetrical admissions are encouraged to be certified when the pregnancy is confirmed. The exception is that of an elective C-section, which must be certified as an elective admission.

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

If an Urgent Care Situation occurs, Participants should contact their Primary Care Provider and/or Practitioner (PCP) immediately, if one has been selected, and follow his or her instructions. Prior Authorization is not required for an Urgent Care Situation or Emergency Medical Condition. A Participant may always go directly to an In-Network urgent care or after-hours clinic.

Determination and Review Process - OVERVIEW

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 Customer Service. We will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received; or
- You may file an Appeal if you have received an Adverse Benefit Determination. Please see Section 10 for more information on the Appeals Process.

The Plan's claims procedures are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Because this Plan is subject to ERISA, we will process your claim according to ERISA standards and provide you with ERISA appeal rights. In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), criteria for medical necessity determinations is available upon request to any current or potential participant, beneficiary, or contracting provider.

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

Adverse Determinations

If the Plan's determination is an Adverse Determination, the Plan shall provide written notice in accordance with the Written Notification Process for Adverse Determinations procedure below. At this point, the Participant can request to Appeal an Adverse Determination. Refer to "Problem Resolution" in Section 10 for details.

Benefit Determination Process

For Benefit Determinations, Customer Service handles the review of SPD language, contractual terms, administrative policies related to benefits as defined by this SPD, and benefits requests that do not involve a medical necessity determination. All benefit determinations that are Adverse will be made by the person assigned to coordinate Benefit, Denial, and Appeal processes.

Customer Service is available between the hours of 8 a.m. and 5 p.m. Central Time, Monday through Friday, by calling SHP's toll-free number (800) 752-5863 | TTY/TDD: (877) 652-1844 *(toll-free)*. After these business hours, you may leave a confidential voicemail for Customer Service and someone will return your call on the next business day. You may also fax SHP at (605) 328-6812.

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

Prospective (Standard/Non-Urgent) Review Process for Benefit Determination Requests

A person assigned to coordinate the benefit, denial and Appeal process will review the request against the Summary Plan Description and Plan policies. A benefit determination will be made within fifteen (15) calendar days of receipt of the request. If SHP is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fifteen (15) calendar days. Within fifteen (15) calendar days of the request for authorization (Certification), SHP must notify the Participant, or Participant's Authorized Representative, of the need for an extension and the date by which it expects to make a decision.

Lack of Necessary Information

If SHP is unable to make a decision *due to lack of necessary information*, it must notify the Participant or the Participant's Authorized Representative of what specific information is necessary to make the decision within fifteen (15) calendar days of the Prospective (Pre-service) Review request. SHP must give the Participant a reasonable amount of time taking into account the circumstances, but not less than forty-five (45) calendar days to provide the specified information. In addition to notifying the Participant, SHP will notify the Practitioner and/or Provider of the information needed if the request for health care services came from the Practitioner and/or Provider.

Timeframe Extensions

If SHP is unable to make a benefit determination due to matters beyond its control, it may extend the decision timeframe once, for up to fifteen (15) calendar days. SHP will give written or electronic notification of the determination to certify or deny the service within fifteen (15) calendar days of the request (or in the case of an extension, by the end of the timeframe given to provide information) to the Participant.

Adverse Determinations

If SHP's benefit determination is an Adverse Determination, SHP shall provide written notice in accordance with the Written Notification Process for Adverse Determinations procedure below. At this point, the Participant can request an appeal of Adverse Determinations. Refer to "Problem Resolution" in Section 10 for details.

Retrospective (Standard/Non-Urgent) Review Process for Medical Care and Benefit Determination Requests

Retrospective (Post-service) Review is used by SHP to review services that have already been utilized by the Participant where such services have not involved a pre-service claim, and where the review is not limited to the veracity of documentation, accuracy of coding, or adjudication for payment.

SHP will review the request and make the decision to approve or deny within thirty (30) calendar days of receipt of the request. Written or electronic notification will be made to the Participant within thirty (30) calendar days of receipt of the request.

If SHP is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fifteen (15) calendar days. Within thirty (30) calendar days of the request for review, SHP must notify the Participant or Participant's Authorized Representative of the need for an extension and the date by which it expects to make a decision.

Utilization Management Review Process

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

The date of receipt for non-urgent (standard) 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 Management Adverse Determinations will be made by the SHP Chief Medical Officer, designee, or appropriate Practitioner.

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

Prior Authorization

Certain services require approval from SHP before services or supplies are rendered. For example, you may be required to obtain Prior Authorization of inpatient hospital benefits or you may be required to obtain a prospective review of other medical services or supplies in order to obtain coverage under the Plan.

Prior/Pre-Authorization (certification) of pre-service claims pertains only to the medical necessity of a service or supply. If we preauthorize a service, we are not telling you that the service or supply is, or will be, covered; we are only telling you that the service or supply meets our Medical Necessity guidelines. For example, we might Prior Authorize your inpatient hospital admission but later deny your claim because the admission was for a service or supply that is excluded under the Plan.

Prior Authorization is an approval by SHP of a requested service prior to a Participant receiving the service. Prior Authorization is designed to facilitate early identification of the treatment plan to ensure medical management and available resources are provided throughout an episode of care.

SHP determines approval for prior authorization based on appropriateness of care and service and existence of coverage. SHP does not compensate practitioners and/or providers or other individuals conducting utilization review for issuing denials of coverage or service care. Any financial incentives offered to Utilization Management decision makers do not encourage decisions that result in underutilization and do not encourage denials of coverage or service.

You are ultimately responsible for obtaining Prior Authorization from Utilization Management. Failure to obtain appropriate Prior Authorization for services will result in a payment reduction to the Out-of-Network Benefit Level. However, information provided by the Physician's office also satisfies this requirement. Participants are responsible to confirm with the In-Network Participating Practitioner and/or Provider that any required Plan Prior Authorization has been obtained. In-Network Participating Practitioners and/or Primary Care Providers, and any Participating Specialists, have been given instructions on how to get the necessary authorizations for surgical procedures or hospitalizations you may need.

NOTE: Only Emergency and/or Urgent Care Services are covered at the In-Network level when provided by an Out-of-Network or Non-Participating Practitioner or Provider. There is no coverage for any other health care service received from an Out-of-Network Participating Practitioner and/or Provider or a Non-Participating Practitioner and/or Provider.

Prior authorization is required for all inpatient admissions of Plan Participants. This requirement applies to, but is not limited to the following:

1. Acute care hospitalizations (includes non-emergency (planned) admissions for medical, surgical, obstetric (other than maternity), and non-emergency (planned) admissions for treatment of a mental health and/or substance use disorder);
2. Residential Treatment Facility admissions; and
3. Rehabilitation center admissions.

For a more detailed listing, see "*Services that Require Prior Authorization*," on the following pages.

NOTE: Admission before the day of non-emergency surgery will not be authorized unless the early admission is medically necessary and specifically approved by SHP. Coverage for hospital expenses prior to the day of surgery will be denied unless authorized prior to being incurred.

Prior Authorization is not a Guarantee of Benefits. All Plan terms and exclusions still apply and may result in a denial of benefits.

Urgent/Emergency Care Request Defined

An **Urgent Care Reques**t is a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Review Request determination:

1. Could seriously jeopardize the life or health of the Participant or the ability of the Participant 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 Participant's medical condition, would subject the Participant 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," SHP shall apply the judgment of a Prudent Layperson, as defined in Section 11. A Practitioner, with knowledge of the Participant's medical condition, who determines a request to be "Urgent" as defined in Section 11, shall have such a request treated as an Urgent Care Request.

Services that Require Prior Authorization

Prior Authorization (Certification) by the Plan is required, but not limited to, the following:

1. Admissions. *See Sections 3(a), 3(b) and 3(d) for coverage details;*,
2. Ambulance Services. *See Section 3(c) for coverage details;*
3. Clinical Trials. *See Section 3(b) for coverage details;*
4. Home Health, Hospice and Home IV therapy services; *See Sections 3(a) and 3(b) for coverage details;*
5. Select Durable Medical Equipment (DME). *See DME requiring Certification in Section 3(a)*;

6. Transplant services; *See Section 3(b) for coverage details;*
7. Implant/Stimulators. *See Section 3(a) for coverage details*;
8. Oncology Services and Treatment. *See Sections 3(a) for coverage details*;
9. Outpatient Services. *See Sections 3(a), 3(b), 3(d) and 3(f) for coverage details;*
10. Outpatient Surgery. *See Sections 3(a), 3(b), 3(d) and 3(f) for coverage details;*
11. Referrals to or services requested from Non-Participating Practitioners and/or Providers or Out-of-Network Participating Practitioners and/or Providers. Certification is required for the purposes of receiving In-Network coverage. If Certification is not obtained for referrals to Non-Participating Practitioners and/or Providers or Out-of-Network Participating Practitioners and/or Providers, the services will be covered at the Out-of-Network level and the Member is responsible for all charges.

Pharmaceutical Review Requests and Exception to the Formulary Process

For any request of: 1) a Non-Covered medication or drug; or 2) a medication, or drug not currently listed in the SHP Formulary, the Plan follows the following process:

1. The Practitioner, Participant, or Participant's Authorized Representative, shall initiate contact with Pharmacy Management via a phone call, email, online fillable form submission, or letter of medical necessity requesting coverage for the specific medication or drug.
2. SHP will review the request based on medical necessity criteria.
3. As needed, medical records showing trial and failure of a formulary drug, or reasons why a formulary drug trial should be bypassed, will be requested.
4. Additional clinical information such as diagnosis, drug fill history, and course of disease progression, may also be requested to make a determination.
5. If the reason for the exception request is not clear, SHP will contact the prescribing provider/practitioner to discuss the case.
6. If needed, a clinical consultant of the appropriate specialty may be consulted for review.
7. SHP will use appropriate practitioners to consider exception requests and promptly grant an exception to the drug formulary, including exceptions for anti-psychotic and other drugs to treat mental health conditions, for a Participant when the practitioner prescribing the drug indicates to SHP that:
   a. the formulary drug causes an adverse reaction in the patient;
   b. the formulary drug is contraindicated for the patient; or
   c. the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

   NOTE: Participants must generally try formulary medications before an exception for the formulary will be made for non-formulary medication use.
8. If the decision is to approve the request, and the request is a standard exception request, the Plan will provide coverage of the non-formulary drug for the duration of the prescription, including refills. If the request is granted and the exception is based on exigent circumstances, the Plan will provide coverage for the duration of the exigency.
9. Standard requests for an exception to the formulary will be determined within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen days after the date the health carrier receives the request.
10. For Expedited (Urgent) requests for an exception to the formulary, a determination will be made as soon as possible, but no later than *seventy-two (72) hours* after the Plan receives the initial request. The Plan will communicate to the Participant and provider will be provided a reason for the denial and the request is a Standard Exception Request, standard appeal rights will be provided and the Participant, applicable Provider(s) and/or Practitioner(s), and if applicable, the Participant's Authorized Representative, will be notified by phone and in writing. At this point, the Participant has the right to request an Appeal of Adverse Determination shall provide written notice in accordance with the *Written Notification Process for Adverse Determinations* procedure below. At this point, the Participant can request an Appeal of Adverse Determination. For more information, see Section 10.

Prospective (Non-urgent Pre-service) Review Process for Elective Inpatient Hospitalizations and Non-Urgent Medical Care

All requests for prior authorization (Certification) are to be made by the Participant or Practitioner's office at least *three (3)* business days prior to the scheduled admission or requested service. Utilization Management will review the Participant's medical request against standard criteria. In order to file a request for prior authorization (Certification) you or your provider must call our Utilization Management toll-free at (800) 805-7938 | TTY/TDD: (877) 652-1844 *(toll-free)*. **Prior Authorization is not a Guarantee of Benefits. All Plan terms and exclusions still apply and may result in a denial of benefits.**

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

a. Patient medical information including:
   i. diagnosis
   ii. medical history
   iii. presence of complications and/orco-morbidities;
b. Consultation with the treating Practitioner, as appropriate;
c. Availability of resources and alternate modes of treatment; and
d. For admissions to facilities other than acute Hospitals additional information may include but are not limited to the following:
   i. history of present illness

ii. patient treatment plan and goals
iii. prognosis
iv. staff qualifications
v. *twenty-four (24)* hour availability of qualified medical staff.

You are ultimately responsible for obtaining Prior Authorization from Utilization Management. Failure to obtain Prior Authorization will result in a reduction to the Out-of-Network Benefit Level. However, information provided by the Practitioner and/or Provider's office also satisfies this requirement.

For Medical Necessity Requests
Utilization Management will review the Participant's profile information against standard criteria. A determination for elective inpatient or non-urgent care will be made by Utilization Management within fifteen (15) calendar days of receipt of the request. If Utilization Management is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fifteen (15) calendar days. Within fifteen (15) calendar days of the request for authorization (Certification), SHP must notify the Participant or Participant's Authorized Representative of the need for an extension and the date by which it expects to make a decision.

Lack of Necessary Information
If SHP is unable to make a decision *due to lack of necessary information*, it must notify the Participant or the Participant's Authorized Representative of what specific information is necessary to make the decision within fifteen (15) calendar days of the Prospective (Pre-service) Review request. SHP must give the Participant a reasonable amount of time taking into account the circumstances, but not less than forty-five (45) calendar days to provide the specified information. In addition to notifying the Participant, SHP will notify the Practitioner and/or Provider of the information needed if the request for health care services came from the Practitioner and/or Provider. The Prospective (pre-service) Review determination shall either be Prior Authorization of the requested service or additional review will be needed by SHP's Chief Medical Officer or designee, however, the decision will be made within fifteen (15) calendar days of that date. If the information is not received by the end of the forty-five (45) calendar day extension, SHP will deny the request.

If SHP receives a request that fails to meet the procedures for prospective review requests, SHP will notify the Practitioner and/or Provider or Participant of the failure, and proper procedures to be followed, as soon as possible but no later than five (5) calendar days after the date of the failure. SHP will give oral and/or written notification to the Participant, Practitioner and those Providers involved in the requested service. We will provide this notification to you only if: (i) your attempt to submit a Prospective (Pre-service) Review request was received by a person or organizational unit of our company that is customarily responsible for handling benefit matters; and (ii) the request contains the name of a Participant, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

Timeframe Extensions
If Utilization Management is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fifteen (15) calendar days. SHP will give written or electronic notification of the determination to certify or deny the service within fifteen (15) calendar days of the request (or in the case of an extension, by the end of the timeframe given to provide information) to the Participant.

Adverse Determinations
If SHP's determination is an Adverse Determination, SHP shall provide written notice in accordance with the Written Notification Process for Adverse Determinations procedure below. At this point, the Participant can request an appeal of Adverse Determinations. Refer to "Problem Resolution" in Section 10 for details.

Concurrent Review Process for Medical Care Requests

Concurrent Review is utilized when a request for an extension of an approved ongoing course of treatment for medical care, including care for behavioral, mental health, and/or substance use disorders, over a period of time or number of treatments, is warranted. Additional stay days must meet the continued stay review criteria and, if acute levels of care criteria are not met, a decision to certify further treatment must be made at that time.

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

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

Requests by You to Extend Previously Approved Care
AParticipant 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 SHP at least *twenty-four (24) hours* in advance of the termination of such continuing services. You may make this request in writing or orally either directly to us or through your treating physician or a hospital representative. To request a concurrent review determination, call Utilization Management at (800) 805-7938 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*.

If Utilization Management denies the extension of treatment, it will advise the Participant and Practitioners and/or Providers within twenty-four (24) hours of receiving the request. If the Participant decides to appeal this denial, the health care services or treatment subject to the Adverse Determination shall be continued without cost to the Participant 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 Participant may pursue the appeal rights described in Section 10.

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

For requests to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, SHP shall make a determination and orally notify the Participant, or the Participant'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 Participant's medical condition, but in no event more than twenty-four (24) hours after the date of SHP's receipt of the request.

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

SHP shall provide written or electronic notification of the Adverse Determination to the Participant 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 Participant or, the Participant'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. SHP will terminate payment of benefits on the date that oral notification of the reduction or termination of benefits is made. In cases where the Participant is not at financial risk, Participants will not be notified of an Adverse Determination unless the decision has the potential to adversely affect the Participant, 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 Concurrent Reviews
If your request for additional care is urgent, and if you submit it no later than twenty-four (24) hours before the end of your pre-approved stay or course of treatment, SHP 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, SHP will give telephone notification of the decision to Participants, Practitioners and those Providers involved in the provision of the service within twenty-four (24) hours of receipt of the request. SHP will give oral, written or electronic notification of the decision to the Participant, 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 you attempt to file an urgent concurrent review but fail to follow our procedures for doing so, we will notify you of the failure within twenty-four (24) hours. Our notification may be oral, unless you ask for it in writing. SHP will provide this notification to you only if: (i) your attempt to submit a pre-service claim was received by a person or organizational unit of our company that is customarily responsible for handling benefit matters; and (ii) your submission contains the name of a Participant, a specific medical condition or symptom, and a specific treatment or service for which approval is being requested.

Adverse Determinations
If SHP's determination is an Adverse Determination, SHP shall provide written notice in accordance with the Written Notification Process for Adverse Determinations procedures outlined below. At this point, the Participant 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. SHP will tell you what further information is needed. You will then have forty-eight (48) hours to provide us with the additional information. SHP 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.

Retrospective (Standard/Non-Urgent) Review Process for Medical Care Requests

Retrospective (Post-service) Review is used by Sanford Health Plan to review services that have already been utilized by the Participant where such services have not involved a pre-service claim, and where the review is not limited to the veracity of documentation, accuracy of coding, or adjudication for payment.

Sanford Health Plan will review the request and make the decision to approve or deny within thirty (30) calendar days of receipt of the request. Written or electronic notification will be made to the Participant within thirty (30) calendar days of receipt of the request. If

Utilization Management is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fifteen (15) calendar days. Within thirty (30) calendar days of the request for review, Sanford Health Plan will notify the Participant or Participant's Authorized Representative of the need for an extension and the date by which it expects to make a decision.

Written Notification Process for Adverse Medical Care and/or Benefit Determinations

The written notification for an Adverse Determination will include the following:

1. The specific reason for the Adverse Determination in easily understandable language.
2. Reference to the specific internal Plan rule, guideline, or protocol on which the determination was based and notification that the Participant will be provided a copy of the actual Plan provisions, guidelines, and protocols free of charge upon request. Reasons for any denial or reimbursement or payment for services with respect to benefits under the Plan will be provided within 30 days of a request.
3. If the Adverse Determination is regarding coverage for a mental health and/or substance use disorder, a statement notifying Participants 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 Participant failing to submit necessary information, the notice shall include a description of any additional material or information, which the Participant 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 treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the Plan to the Participant's medical circumstances, or a statement that an explanation will be provided to the Participant 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 days of a Participant/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 SHP's Appeal procedures, including how to obtain an expedited review if necessary (and any time limits applicable to those procedures) including:
    a. a Participant's right to bring civil action under §502(a) of ERISA;
    b. the right to submit written comments, documents or other information relevant to the appeal;
    c. an explanation of the Appeal process including the right to Participant 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 Participant 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 Physician or appropriate Practitioner to discuss the determination.

Section 3.Covered Services – OVERVIEW

Section 3(a) Medical services & supplies provided by Physicians and other health care professionals

IMPORTANT

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 Summary Plan Description and are payable only when they are Medically Necessary.
- Be sure to read Section 2, *How you get care*, for valuable information about conditions for coverage.
- You or your Physician must get Prior Authorization of some services in this Section. The benefit description will say "**NOTE:** Prior Authorization is required for certain services. Failure to get Prior Authorization will result in a reduction or denial of benefits *(See Services requiring Prior Authorization in Section* 2.)"

IMPORTANT

Benefit Description

Diagnostic and treatment services

Professional services from Physicians, nurse practitioners, and Physician's assistants are covered when provided in:

- In Physician's office, an urgent care center, medical office consultations, electronic-consults/telehealth, and second surgical opinions

Lab, x-ray and other diagnostic tests benefit

- Blood tests
- CT Scans/MRI
- DEXA Scans
- Electrocardiogram (EKG)
- Electroencephalography (EEG)
- Genetic testing, and counseling, medically necessary to help establish a diagnosis of a new or inheritable disease
- Non-routine mammograms
- Non-routine Pap tests
- Non-routine PSA tests
- Pathology
- PET Scans
- Ultrasound
- Urinalysis
- X-rays

Not Covered: *Thermograms or thermography*

Telehealth, e-visit, and video visits benefit

Per Plan guidelines *(available upon request)*, telemedicine, e-visit, and video visit services is covered and available through a secured interactive audio, video, or email connection. Access to services may be done through a smart phone, tablet or computer. For non-emergency health issues, coverage under this section includes but is not limited to diagnosis, consultation, or treatment.

Telemedicine, e-visit, and video visit services must be rendered by a SHP-approved Provider and/or Practitioner.

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

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

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

Not Covered:

- Transmission fees
- Services for excluded benefits
- Services not medically appropriate or necessary
- Installation or maintenance of any telecommunication devices or systems
- Provider-initiated e-mail
- Appointment scheduling
- A service that would similarly not be charged for in a regular office visit
- Reminders of scheduled office visits
- Requests for a referral
- Consultative message exchanges with an individual who is seen in the provider's office following a video visit for the same condition, per Plan guidelines
- Clarification of simple instructions

Preventive care benefit – OVERVIEW, adults & children

Preventive Care coverage is as follows:

Under §2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services, the following services, when received from an In-Network Participating Practitioner and/or Provider, are covered without payment of any deductible, copayment, or coinsurance requirement that would otherwise apply:

1. Evidenced-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) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009;
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of USPSTF. You do not need Certification from SHP, or any other person or entity, in order to obtain access to obstetrical and/or gynecological care through an In-Network Participating Practitioner and/or Provider.

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

Not Covered:

- *Non-routine physicals, including but not limited to: Sports physicals, pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses)*
- *Virtual colonoscopies*
- *Immunizations for travel*

Preventive care benefit details, adults

FOR WOMEN ONLY

The Plan will cover preventive/wellness services in accordance with the age and frequency provisions under the Affordable Care Act as recommendations by the Health Resources and Services Administration (HRSA). Participant payment of deductible, copayment, or coinsurance is not required for the women's preventive care services as recommended by the HRSA. Services include but are not limited to:

- Annual gynecological exam
- Cervical cancer screening; includes Pap smear test at intervals specified in SHP's Preventive Health Guidelines
- Genetic Counseling and evaluation for BRCA Testing and BRCA lab screening for women who have a family history of breast, ovarian, tubal, or peritoneal cancer and an increased risk for potentially harmful mutations in breast cancer susceptibility genes ($BRCA_1$ or $BRCA_2$)
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40 years of age
- Screening for certain sexually transmitted diseases screening including HIV, gonorrhea, chlamydia and syphilis
- Domestic and interpersonal violence screening and counseling for all women
- Osteoporosis screening for women over age 60 depending on risk factors
- Tobacco Use screening and interventions for all women

For a full listing of covered women's preventive/wellness services, log into your account and view SHP's Preventive Health Guidelines at www.sanfordhealthplan.com.

FOR MEN ONLY

- One-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.

Prostate Screening

- One prostate cancer screening including PSA every year:
  - Ages *fifty (50)* and older; or
  - Ages *forty (40)* and older who are symptomatic or in a high risk category

Preventive care benefit details, children

The Plan will cover preventive/wellness services in accordance with the age and frequency provisions under the Affordable Care Act as recommendations by the Health Resources and Services Administration (HRSA). Participant payment of any deductible, copayment, or coinsurance is not required for preventive care services as recommended by the HRSA. Services include but are not limited to:

- Pediatric immunizations/vaccines (including those recommended for children by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention)
- Routine history and physical examination, including:

- Medical history
- Height and weight measurement
- Physical examination
- Counseling on health improvement, where appropriate, per Preventive Guidelines
- Routine vision (chart) exam – when part of a comprehensive preventive/wellness exam
- Rotavirus vaccine
- Hepatitis B vaccine

For a full listing of covered children's preventive/wellness services, log into your account and view SHP's Preventive Health Guidelines at www.sanfordhealthplan.com/memberlogin.

Not Covered:

- *Non-routine physicals, including but not limited to: Sports physicals, pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses)*
- *Virtual colonoscopies*
- *Immunizations for travel*

Tobacco cessation treatment benefit

Tobacco cessation treatment coverage is as follows:

As defined in the Patient Protection and Affordable Care Act, 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 Participating Practitioner and/or Provider are covered without payment of any deductible, copayment, or coinsurance requirement that would otherwise apply. Tobacco cessation treatment includes:

- Screening for tobacco use; and
- At least two (2) tobacco cessation attempts per year (for participants who use tobacco products). Covering a cessation attempt is defined to include coverage for:
  - Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization, and
  - 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.

Not Covered: *Hypnotism and Acupuncture*

Prenatal and postpartum maternity care benefit

Maternity coverage is as follows:

NOTE: Due to the inability to predict admission, you or your Physician are encouraged to notify SHP of your expected due date when the pregnancy is confirmed. You are also encouraged to notify SHP of the date of scheduled C-sections when it is confirmed.

Covered maternity services include but are not limited to:

- Screening for gestational diabetes mellitus during pregnancy – Testing includes a screening blood sugar followed by a glucose tolerance test, if the sugar is high.
- Anemia screening
- Bacteruria (bacteria in urine) screening
- Hepatitis B screening
- Rh (Rhesus) incompatibility screening: first pregnancy visit and 24-28 weeks gestation
- Genetic counseling, or testing, that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force or are approved by the Chief Medical Officer, per Plan guidelines. Prior authorization is required.

Maternity care includes prenatal through postnatal maternity care and delivery, and care for complication of pregnancy of mother. SHP covers up to four (4) routine ultrasounds per pregnancy to determine fetal age, size, and development, per Plan guidelines.

Breastfeeding support, supplies and counseling are covered in the following manner: the Plan will cover one breast pump (electric or manual, non-hospital grade) per pregnancy. Replacement tubing, breast shields, and splash protectors are also covered. Bottles, breast milk storage bags and supplies related to bottles are not covered. Pumps and supplies are covered only when obtained from a SHP Participating durable medical equipment Provider. This does not include drugstores or department stores. In addition to pumps, consultation with a lactation (breastfeeding) specialist is also covered.

Newborns' Act Disclosure

The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of forty-eight (48) hours for a vaginal delivery to a minimum of ninety-six (96) hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Physician, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If such an inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by In-Network Participating Practitioners and/or Provider s competent in postpartum care and newborn assessments. In any case, group health plans may not, under federal law, require that a provider obtain Prior Authorization from SHP for prescribing a length of stay not in excess 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.

NOTE: SHP encourages you to participate in our Healthy Pregnancy Program. Call (888) 315-0884 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)* to enroll.

Not Covered: *Amniocentesis or chorionic villi sampling (CVS) solely for sex determination*

Newborn (postnatal) care benefit

Newborn coverage is as follows:

A newborn is eligible to be covered from birth. Participants must complete the enrollment process requesting coverage for the newborn within thirty (30) days of the infant's birth. For more information, see Section 1 on Enrollment and *When Dependent Coverage Begins* in this Summary Plan Description.

SHP covers care for the enrolled newborn child from the moment of birth including care and treatment for illness, injury, premature birth and medically diagnosed congenital defects and birth abnormalities (Please refer to "Reconstructive Surgery" in Section 3(b) for coverage information of surgery to correct congenital defects).

SHP will cover other care of an enrolled newborn child who requires non-routine treatment only if we cover the Employee as a Participant. The deductible amount is waived for the first thirty (30) days following the date of birth.

NOTE: You or your Physician must get Authorization/Certification of neonatal intensive care nursery services. Failure to get Authorization may result in a reduction or denial of benefits. *(See Services requiring Prior Authorization in Section* 2.)

Not Covered:

- *Newborn delivery and nursery charges for adopted Dependents prior to the adoption bonding period*
- *Expenses related to surrogacy, including surrogate pregnancy and delivery*

Family planning/contraceptive services benefit

Family planning coverage is as follows:

- Family Planning Services include consultations, and pre-pregnancy planning.
- Genetic testing and counseling medically necessary to help establish a diagnosis of an inheritable disease.
- Contraception including injectable contraceptive drugs and IUD implantable devices per Plan guidelines. **NOTE:** See prescription drug benefits in Section 3(e)
- Folic acid supplements are covered at 100% (no cost) for women planning to become pregnant or in their childbearing years.

Coverage includes the following contraception methods/services:

- Barrier methods: diaphragm and cervical cap fitting and purchase.
- Implantable devices; including intrauterine devices. Placement and removal is covered once every five (5) years or as medically necessary.
- Vasectomies
- Sterilizations for women, including tubal ligations and vasectomies:
  - Medical – Occlusion of the fallopian tubes by use of permanent implants.
  - Surgical – Tubal ligation covered at 100% of allowed only when performed as the primary procedure. When performed as part of a maternity delivery or any other medical reason, it will be covered as a medical benefit with the applicable cost-share applied.
- Generic contraceptives are covered at 100% (no charge). (See your Summary of Pharmacy Benefits/Formulary)
- Other contraceptives including injectable medroxyprogesterone acetate and emergency contraception (generic Plan B) are also covered at 100% (no charge).

Not Covered:

- *Genetic counseling or testing, except for services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force or are approved by the Chief Medical Officer, per Plan Guidelines; prior authorization (Certification) is required*
- *Reproductive Health Care Services prohibited by law*
- *Elective abortion services, except for those necessary to prevent the death of the woman. No benefits are available for removal of all or part of a multiple gestation.*
- *Reversal of voluntary sterilization, including vasectomies*
- *Any expenses related to surrogate pregnancies*

Infertility services benefit

Infertility benefits coverage is as follows:

- SHP covers testing for the diagnosis of infertility. Limited to Plan Guidelines.

Not Covered:

- *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;*
- *Cryogenic or other preservation techniques used in such or similar procedures;*

- *Infertility medication;*
- *Any other services or supplies related to artificial means of conception;*
- *Reversals of prior sterilization procedures; and*
- *Any expenses related to surrogate pregnancies or any surrogate means of gestation.*

Allergy care benefit

Allergy care coverage is as follows:

Testing and treatment, Allergy injections, and Allergy serum are covered.

Not Covered:

- *Provocative food testing and sublingual allergy desensitization*
- *Specific non-standard allergy services and supplies including but not limited to skin titration (Rinkle method), cytotoxicity testing (Bryan's Test), treatment of non-specific candida sensitivity, and urine autoinjections*

Chiropractic services benefit

Chiropractic services coverage is as follows:

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

Not Covered: *Vitamins, minerals, therabands, cervical pillows, traction services, and hot/cold pack therapy including polar ice therapy and water circulating devices*

Outpatient nutrition care services benefit

Coverage is provided for Participants with the following diagnoses:

- Hyperlipidemia
- Gestational Diabetes – coverage provided at 100% (No charge); see *Maternity Care* in this Section for details.
- Chronic Renal Failure
- Diabetes Mellitus – subject to Deductible/Cost-Sharing; see *Diabetes supplies, equipment, and education services benefit* in this Section for details.
- Anorexia Nervosa – subject to Deductible/Cost-Sharing
- Bulimia– subject to Deductible/Cost-Sharing
- Morbid Obesity
- Celiac Disease

Coverage is limited to the closest available In-Network qualified education program that provides the necessary management training to accomplish the prescribed treatment. Benefits may be subject to medical necessity and medical review. Applicable cost sharing may apply, including coverage limitations until Deductible is met by the Participant.

Phenylketonuria (PKU) treatment services benefit

Phenylketonuria Coverage is as follows:

- Testing, diagnosis and treatment of Phenylketonuria including dietary management, formulas, Case Management, intake and screening, assessment, comprehensive care planning and service referral.

Not Covered: *PKU dietary desserts and snack items*

Amino acid-based elemental oral formulas benefit

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

- Coverage for medical foods and low-protein modified food products determined by a Practitioner and/or Provider to be medically necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.

Not Covered:

- *Dietary desserts and snack items*
- *Low protein modified food products or medical food for PKU to the extent those benefits are available under a government program that provides coverage for the same*

Dialysis benefit

Dialysis for renal disease coverage is as follows:

NOTE: Prior Authorization is required for home dialysis therapy; failure to get Prior Authorization will result in a reduction or denial of benefits *(See Services requiring Prior Authorization in Section 2):*

- Dialysis for renal disease, unless or until the Participant qualifies for federally funded dialysis services under ESRD. Services include equipment, training, and medical supplies required for effective dialysis care. Coordination of Benefit (COB) Provisions apply; see

Section 6.

Diabetes supplies, equipment, and education services benefit

Diabetic Services coverage is as follows:

Note: Indicated Durable Medical Equipment (DME) requires Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 2.)

- Blood glucose monitors, including continuous glucose monitoring systems (CGM); *This is a DME that requires Certification.*
- Blood glucose monitors for the legally blind
- Test strips for glucose monitors
- Urine testing strips
- Insulin pumps and all supplies for the pump; *This is a DME that requires Certification.*
- Syringes
- Insulin infusion devices; *This is a DME that requires Certification.* Prescribed oral agents for controlling blood sugars
- Glucose agents
- Glucagon kits
- Diabetes pump supplies (covered under a $24 copay)
- Dilated eye examination for diabetes-related diagnosis – limited to one (1) exam per Participant per calendar year. Details listed in this Section under *Vision services (testing, treatment, and supplies)*
- Insulin measurement and administration aids for the visually impaired and other medical devices for the treatment of diabetes
- Routine foot care including toe nail trimming
- Insulin injection aids
- Lancets and lancet devices
- 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
- Diabetes self-management training and education

Diabetes self-management training and education shall only be covered if:

- The service is provided by a Physician, nurse, dietitian, pharmacist or other licensed health care Practitioner and/or Provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified by a diabetes educator and;
- The training and education is based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association.

Not Covered: *Food items for medical nutrition therapy.*

Diabetes Intervention Program

Participants with Type 2 Diabetes may be eligible to enroll in a structured, personalized nutrition plan through Profile to assist in weight loss and a goal of better symptom management. The program consists of a one-year Profile by Sanford membership where Participants will have accesses to 1-on-1 coaching, a personalized nutrition plan, smart tracking technology, and a 20-week educational resource guide.

To participate, Participants must agree to:

- Follow the structured nutrition plan as recommended;
- Attend a minimum of 20 Profile personal coaching appointments before also engaging with the Sanford Health Plan wellness team; and
- Continue to adhere to their broader Sanford Health Plan care management program.

Program Costs

- Shared Costs: Sanford Health Plan Members, Sanford Health Plan, and Profile by Sanford will jointly share in program costs. Profile by Sanford members, on average, invest approximately $2,000 per year on membership and Profile food costs.

Enrollment in the program is based on Medical Necessity and approval by the SHP's Chief Medical Officer. Eligibility criteria for potential candidates includes:

- Diagnosis with Diabetes Mellitus, Type 2;
- BMI of 25 or Greater;
- Have a HgbA1C greater than or equal to 7.5; and
- Currently take Metformin and be on at least 2 other anti-diabetic agents.

Eligible Participants will be contacted by SHP will instructions on how to enroll in the program.

Outpatient rehabilitative physical, speech, and occupational therapy services benefit

Outpatient rehabilititative physical, speech, and occupational therapy coverage is as follows:

- Outpatient Rehabilitative Therapy (Physical Therapy, Occupational Therapy, and Speech Therapy services directed at improving physical functioning of the Participant) which is expected to provide significant improvement within *two (2)* months, as certified on a prospective and timely basis by SHP.
- Coverage is limited to *forty-five (45*) visits per therapy per Calendar Year

- Includes One-to-one water therapy

Not Covered:

- *Traction services*
- *Non-medical special education services or educational counseling for learning disorders or mental disabilities*
- *Maintenance Care that is typically long-term, by definition not therapeutically necessary but is provided at regular intervals to promote health and enhance the quality of life; this includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, or habilitative care to prevent symptomatic deterioration and/or initiated by Participants without symptoms in order to promote health and to prevent further problems*
- *Services provided in the Participant's home for convenience, that are not expected to make measurable or sustainable improvement within a reasonable period of time including therapy for chronic and/or recurring symptoms including but not limited to arthritis, back pain, and fibromyalgia*
- *Hot/cold pack therapy including polar ice therapy and water circulating devices*
- *Speech therapy for the purpose of correcting speech impediments (stuttering or lisps), or assisting the initial development of verbal faculty or clarity; voice training and voice therapy*
- *Therapy for a primary diagnosis of developmental delay disorder*
- *Habilitative therapies*

Treatment therapy benefits not otherwise listed in this SPD

Treatment therapy is as follows:

Note: Indicated Oncology Services requires Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 2.)

- Inhalation Therapy
- Radiation Therapy. *This is an Oncology Service/Treatment that requires Certification.*
- Chemotherapy, regardless of whether the Participant has separate prescription drug benefit coverage. *This is an Oncology Service/Treatment that requires Certification.*
- Pheresis Therapy
- Respiratory Therapy Services; limited to one (1) program per episode of care
- Cardiac Therapy Services; limited to one (1) program per episode of care
- Pulmonary Rehabilitation Services; limited to one (1) program per episode of care

Hearing services benefit (testing, treatment, and supplies)

Hearing services coverage is as follows:

- Diagnosis and treatment of sudden sensorineural hearing loss (SSNHL)
- Diagnostic testing and treatment related to acute illness or injury.

NOTE: Indicated Durable Medical Equipment (DME) and Implant/Stimulators require Certification; Failure to get Certification will result in a reduction or denial of benefits (See Services requiring Certification in Section 2.):

- External hearing aids when caused by an acute illness, injury, or congenital defect. *This is a DME that requires Certification.*
- Cochlear implants and bone-anchored (hearing-aid) implants. *This is an Implant/Stimulator that requires Certification.*

Not Covered:

- *Treatment of gradual deterioration of hearing that occurs with aging and/or other lifestyle factors, and related adult hearing screening services, testing and supplies*
- *External hearing aids, non-implant devices, or equipment to correct gradual deterioration of hearing that occurs with aging and/or other lifestyle factors and is not caused by acute illness or injury*
- *Tinnitus Maskers*
- *All other hearing related supplies, purchases, examinations, testing or fittings unless otherwise specified as covered*

Vision services benefit (testing, treatment, and supplies)

Vision services coverage is as follows:

- Eye exams for child(ren) up to age 18 to determine the need for vision correction (chart exam) when part of a routine preventive/wellness office visit exam
- Non-routine eye exams for the treatment of an acute disease or injury
- Dilated eye examination for diabetes-related diagnosis; limit one (1) exam per Participant per Benefit Year
- Scleral shells
    - Maximum benefit limit of two soft shells per Participant per calendar year. Hard shells limited to one (1) per Participant per lifetime.
- For Participants with a diagnosis of Aphakia, benefit is Participant's choice of either:

- One (1) pair of eyeglasses; includes lenses and frame. Maximum benefit limit of one (1) frame per lifetime; or
- Two (2) single clear contact lenses for the aphakic eye per Participant per calendar year.

Not Covered:

- *Vision exams (routine) unless otherwise specified as covered in this SPD*
- *Refractive errors of the eye*
- *Purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically covered elsewhere*
- *Radial Keratotomy, Myopic Keratomileusis, and any surgery involving corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error*
- *Replacement of lost, stolen, broken, or damaged lenses or glasses*
- *Bifocal contact lenses*
- *Special lens coating or lens treatments for prosthetic eyewear*
- *Glasses and/or contacts after cataract surgery*
- *Routine cleaning of Scleral Shells*

Foot care benefits

Foot care coverage is available for the following:

- Routine foot care for Participants with diabetes only, per Plan guidelines (available upon request). See Section 3(a) *Diabetes supplies, equipment, and education* for more information on Plan benefits.
- Non-routine diagnostic testing and treatment of the foot due to illness or injury.

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

Not Covered:

- *Cutting, removal, or treatment of corns, bunions (except capsular or related surgery), calluses, or nails for reasons other than authorized corrective surgery (except as stated above and in Section 3(a) Diabetes supplies, equipment, and education)*
- *Diagnosis and treatment of weak, strained, or flat feet*

Orthotic and prosthetic devices benefit

Orthotic and prosthetic device coverage is as follows:

Note: Indicated Durable Medical Equipment (DME) requires Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 2.)

- Prosthetic limbs, sockets and supplies, and prosthetic eyes
- 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.
- Adjustments and/or modification to the prosthesis required by wear/tear or due to a change in Participant's condition or to improve the function are eligible for coverage and do not require prior authorization.
- 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 prosthesis.
- 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.*

NOTE: Internal prosthetic devices are paid as Hospital benefits; see Section 3(b) for payment information. Insertion of the device is paid under the surgery benefit.

Not Covered:

- *Experimental and/or Investigational Services not part of an Approved Clinical Trial, unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies*
- *Revision/replacement of prosthetics except as noted per Plan guidelines (available upon request)*
- *Replacement or repair of items, if the items are damaged or destroyed by the Participant's misuse, abuse or carelessness; or lost or stolen*
- *Duplicate or similar items*
- *Service call charges, labor charges, charges for repair estimates*
- *Wigs, cranial prosthesis, or hair transplants*
- *Cleaning and polishing of prosthetic eye(s)*

Durable medical equipment (DME) benefit

Durable medical equipment (DME) coverage is as follows:

- Covered DME equipment prescribed by an attending Physician that is Medically Necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury. Plan

medical necessity and limitation guidelines apply (available upon request).

- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Plan medical necessity and limitation guidelines.

NOTE: The following DME require Prior Authorization; failure to get Prior Authorization will result in a reduction or denial of benefits. *(See Services requiring Prior Authorization in Section* 2.):

- Airway Clearance Device
- Beds such as Hospital beds and mattresses
- Communication Device
- Continuous Glucose Monitors and Sensors
- Cranial Molding Helmet
- Dental Appliances
- Home INR Monitor
- Insulin Pump
- Selected Orthotics
- Phototherapy UVB Light Device
- Pneumatic Compression with external pump
- Prosthetic Limb

Not Covered:

- *Home Traction Units*
- *Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliances*
- *Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage*
- *Revision of durable medical equipment, except when made necessary by normal wear or use*
- *Replacement or repair of equipment if items are lost or stolen; or damaged or destroyed by Participant misuse, abuse, or carelessness*
- *Duplicate or similar items*
- *Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates*
- *Items which are primarily non-medical and educational in nature or for vocation, comfort, convenience or recreation*
- *Communication aids or devices to create, replace or augment communication abilities including, but not limited to, hearing aids (unless otherwise specified as covered in this SPD), speech processors, receivers, communication boards, or computer or electronic assisted communication*
- *Household equipment whose primary use is customarily non-medical, including but not limited to air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools*
- *Household fixtures including but not limited to escalators or elevators, ramps, swimming pools and saunas*
- *Home Modifications including but not limited to wiring, plumbing or changes for installation of equipment*
- *Vehicle modifications including but not limited to hand brakes, hydraulic lifts, and car carriers*
- *Remote control devices as optional accessories*
- *Any other equipment and supplies which SHP determines is not eligible for coverage*

Implants/Stimulators

Implants/Stimulators coverage is as follows:

Implants and Stimulators prescribed by an attending Practitioner and/or Provider and are Medically Necessary are covered. Limitations per Certificate of Insurance guidelines apply (available upon request).

Note: The following Implants/Stimulators require Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval (Certification) in Section 2.):

- Bone Growth (external)
- Cochlear Implant (Device and Procedure)
- Deep Brain Stimulation
- Gastric Stimulator
- Spinal Cord Stimulator (Device and Procedure)
- Vagus Nerve Stimulator

Home health services benefit

NOTE: Prior Authorization is required; failure to get Prior Authorization will result in a reduction or denial of benefits. *(See Services requiring Prior Authorization in Section* 2.)

- Participant must be homebound to receive home health services.

The following Home Health Services are covered in lieu of an inpatient stay, if approved (certified) by SHP:

- Part-time or intermittent skilled 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 Plan benefit.
- Medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Participant were Hospital
- Limited to 40 visits in a calendar year and does not include meals, custodial care or housekeeping
- Skilled behavioral health services

NOTE: As skilled nursing or home health aide visit is defined as a visit of up to a consecutive 4-hour period of time in duration. Abehavioral health visit is defined as a visit of up to 1 hour in duration.

Not Covered:

- *Nursing care requested by, or for the convenience of the patient or the patient's family (rest cures)*
- *Charges for meals or housekeeping*
- *Custodial or convalescent care*
- *Long-term residential care*
- *Maintenance care*

Section 3(b) Services provided by a Hospital or other Facility

IMPORTANT

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 Summary Plan Description and are payable only when they are Medically Necessary.
- In-Network Participating Providers must provide or arrange your care and you must be Hospitalized in an In-Network Facility.
- Mental Health and Substance Use Disorder benefits provided by a Hospital or other Facility are outlined in Section 3(d).
- Be sure to read Section 2, *How you get care*, for valuable information about conditions for coverage.
- **YOU MUST GET PRIOR AUTHORIZATION OF SOME OF THESE SERVICES**. See the benefits description below.

IMPORTANT

Benefit Description

Admissions

NOTE: Prior Authorization is required for all non-emergency Inpatient admissions (a stay overnight) in a hospital or other facility; failure to get Prior Authorization will result in a reduction or denial of benefits *(See Services requiring Prior Authorization in Section* 2.)

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 SHP
- 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 Physician and/or Practitioner during Hospitalization. *Some specific services may require authorization. See Section 2 or contact SHP for benefit details.*

NOTE: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the Hospital at least forty-eight (48) hours after the procedure. For benefit details, see the Notice of Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA) in Section, under *Reconstructive Surgery*.

Not Covered:

- *Take-home drugs*
- *Personal comfort items (telephone, television, guest meals and beds)*
- *Private nursing care*
- *Admissions to Hospitals only for the convenience of the Participant, the Participant's family or the Participant's Physician or other Practitioner and/or Provider*
- *Custodial or Convalescent care*
- *Intermediate level or domiciliary care*
- *Rest cures*
- *Services to assist in activities of daily living (ADLs)*

Skilled nursing care facility benefit

Skilled Nursing Facility coverage is as follows:

NOTE: Prior Authorization is required; failure to get Prior Authorization will result in a reduction or denial of benefits *(See Services requiring Prior Authorization in Section* 2.)

Skilled Nursing Facility Services are covered if approved by SHP in lieu of continued or anticipated Hospitalization. The following Skilled Nursing Facility Services are covered when provided through a 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 any consecutive twelve (12) month period. Skilled nursing care in a Hospital shall be covered if the level of care needed by a Participant 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 health care Facility within a thirty-mile (30) radius of the Hospital.

Not Covered:

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

Hospice care benefit

Hospice Care coverage is as follows:

NOTE: Prior Authorization is required; failure to get Prior Authorization will result in a reduction or denial of benefits *(See Services requiring Prior Authorization in Section* 2.)

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

1. The Participant has been diagnosed with a terminal disease and a life expectancy of six (6) months or less;
2. The Participant has chosen a palliative treatment focus (i.e. emphasizing comfort and support services rather than treatment attempting to cure the disease or condition);
3. The Participant continues to meet the terminally ill prognosis as reviewed by SHP's Chief Medical Officer or designee over the course of hospice care;and
4. The hospice service has been approved by SHP.

The following Hospice Services are Covered Services:

1. 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
2. In-home hospice care per Plan guidelines (available upon request)
3. Part-time or intermittent nursing care by a RN, LPN/LVN, or home health aide for patient care up to eight (8) hours per day
4. Social services under the direction of an In-Network Participating Practitioner and/or Provider
5. Psychological and dietary counseling
6. Physical or occupational therapy, as described under *Section3(a)*
7. Consultation and Case Management services by an In-Network Participating Practitioner and/or Provider
8. Medical supplies, DME and drugs prescribed by an In-Network Participating Practitioner and/or Provider
9. Expenses for In-Network Participating Practitioners and/or Provider s for consultant or Case Management services, or for physical or occupational therapists, who are not group members of the hospice, to the extent that coverage for these services is listed in *Section 3(a),* but only where the hospice retains responsibility for the care of the Participant

Not Covered:

- *Independent nursing, homemaker services, or respite care*
- *Fees associated with Room and Board unless Prior Authorization is received pursuant to Medical Necessity guidelines*

Outpatient surgical services benefit

Outpatient surgical services coverage is as follows;

NOTE: Prior Authorization is required; failure to get Prior Authorization will result in a reduction or denial of benefits *(See Services requiring Prior Authorization in Section* 2.)

Health care services furnished in connection with a surgical procedure are covered when performed in an In-Network participating surgical center, which includes:

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

NOTE: See SHP's Provider Directory at www.sanfordhealthplan.com for a listing of facilities able to provide services under this benefit. Coverage of some procedures at surgical centers is limited by contract. Check with SHP and your Provider to ensure services from an In-Network participating surgical center will be covered for your particular procedure.

Not Covered:

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

Oral and maxillofacial surgery benefit

Oral and maxillofacial surgery coverage is as follows:

NOTE: Indicated services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 2.)

- Oral surgical procedures limited to services required because of injury, accident, or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.*.
    - Care must be received within *six (6)* months of the occurrence
- Orthognathic Surgery per 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. *This is a DME that requires Certification.*
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
    - is a child over age five (5); or
    - is severely disabled or otherwise suffers from a developmental disability; or
    - has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.
- For more information on dental benefits, see Section 3(f).

Not Covered:

- *Routine dental care and treatment*
- *Osseointegrated implant surgery (dental implants)*
- *Natural teeth replacements including crowns, bridges, braces or implants*
- *Extraction of wisdom teeth*
- *Hospitalization for extraction of teeth*
- *Dental x-rays or dental appliances*
- *Shortening of the mandible or maxillae for cosmetic purposes*
- *Services and supplies related to ridge augmentation, implant ology, and Preventive vestibuloplasty*
- *Dental appliances of any sort, including but not limited to bridges, braces, and retainers, appliances except for treatment of TMJ/TMD*

Reconstructive surgery benefit

Reconstructive surgery coverage is as follows:

NOTE: The following services are considered Outpatient Surgery and require Prior Authorization; failure to get Prior Authorization will result in a reduction or denial of benefits. *(See Services requiring Prior Authorization in Section* 2.)

- Surgery to restore bodily function or correct a deformity caused by illness or injury

Notice of Rights under the Women's Health and Cancer Rights Act Of 1998 (WHCRA):

- In compliance with 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 Participant. Deductible and coinsurance apply, as outlined in your *Summary of Benefits and Coverage*. Mastectomy benefits include:
- Coverage will be provided for reconstructive breast surgery and physical complications at all stages of a mastectomy, including massage therapy and related treatment therapies for lymphedema, for those Participants who had a mastectomy due to disease, illness, or injury.
- For single mastectomy: coverage extends to the non-affected side to make it symmetrical with the affected breast post-surgical reconstruction.
- Breast prostheses and surgical bras and replacements are also covered *(see Orthotic and Prosthetic devices in Section 3(b) for details).*

Not Covered:

- *Cosmetic Services and/or supplies to repair or reshape a body structure that is not medically necessary and/or primarily for the improvement of a Participant's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services. Does not apply to medically necessary services provided pursuant to WHCRA.*
- *Removal, revision or re-implantation of saline or silicone implants for: breast implant malposition; unsatisfactory aesthetic outcome; patient desire for change of implant; patient fear of possible negative health effects; or removal of ruptured saline implants that do not meet medical necessity criteria, unless covered under Plan guidelines for mastectomy benefits.*

Morbid obesity surgical benefit

Morbid objesity surgery coverage is as follows:

NOTE: This is an Outpatient Surgery and Certification is; failure to get Prior Authorization will result in a reduction or denial of benefits.

(See Services requiring Prior Authorization in Section 2.)

- Surgical treatment of morbid obesity (bariatric surgery) is covered per Plan guidelines. Medical management policies define the criteria and coverage limitations.
- Benefits for surgical services performed for the treatment of morbid obesity are available only when:
  1. Prior Approval is obtained; and
  2. Subject to Plan guidelines (available upon request);and
- Limited to a lifetime Maximum of one (1) operative procedure per Participant.

Not Covered:

- *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)*
- *Weight loss or exercise programs that do not meet the Plan's medical necessity coverage guidelines*
- *Appetite suppressants and supplies of a similar nature*
- *Liposuction, gastric balloons, or wiring of the jaw*
- *Panniculectomy that does not meet Plan guidelines*
- *Abdominoplasty*

Transplant services benefit

Transplant services coverage is as follows:

NOTE: Prior Authorization is required; failure to get Prior Authorization will result in a reduction or denial of benefits. (See Services requiring Prior Authorization *in Section* 2.)

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

- Pre-operative care
- Transplant procedure, facility and professional fees
- Organ acquisition costs including:
  - 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
  - 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
- Bone marrow or stem cell acquisition and short term storage during therapy for a Participant with a covered illness
- Short-term storage of umbilical cord blood for a Participant with a malignancy undergoing treatment when there is a donor match.
- Post-transplant care and treatment
- Drugs (including immunosuppressive drugs)
- Supplies (must be Prior Authorized)
- Psychological testing
- 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
  a. **Transplants that meet the United Network for Organ Sharing (UNOS) criteria and/or Plan medical necessity requirements and are performed at In-Network Plan Participating Providers or contracted centers of excellence.**

Not Covered:

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

Anesthesia benefit

The Plan covers services of an anesthesiologist or other certified anesthesia Provider in connection with an authorized inpatient or outpatient procedure or treatment.

Clinical Trials

Clinical Trials coverage is as follows:

NOTE: This requires Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 2.)

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

Not covered:

- *Extra care costs related to taking part in a clinical trial such as additional tests that a Member may need as part of the trial, but not as part of the Member's routine care.*
- *Research costs related to conducting the Approved Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.*

Section 3(c) Emergency services/accidents

IMPORTANT

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 Summary Plan Description 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.

IMPORTANT

Benefit Description

What is an Emergency Medical Condition?

An **Emergency Medical Condition** is the sudden and unexpected onset of a health condition that, based on a Prudent Layperson's judgment, 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, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

What is an Urgent Care Situation?

An **Urgent Care Situation** is a degree of illness or injury, which is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours, such as stitches for a cut finger. If an urgent care situation occurs, Participants should contact their Primary Care Provider and/or Practitioner (PCP) immediately, if one has been selected, and follow his or her instructions. A Participant may always go directly to an In-Network participating urgent care or after-hours clinic (a Provider Directory is available on request or visit www.sanfordhealthplan.com).

Emergency inside SHP Service Area

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

The Participant, or a designated relative or friend, must notify SHP and the Participant's Primary Care Provider and/or Practitioner, if one has been selected, as soon as reasonably possible after receiving treatment for an Emergency Medical Condition; but no later than forty-eight (48) hours after the Participant is physically or mentally able to do so.

The Health Plan covers emergency services necessary to screen and stabilize Participants 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 Practitioner and/or Provider or an Out-of-Network Participating Practitioner and/or Provider within SHP's Service Area, the Plan shall cover emergency services necessary to screen and stabilize a Participant and may not require Prospective (pre-service) Review of such services if a Prudent Layperson would have reasonably believed that use of a Participating and/or In-Network Practitioner and/or Provider would result in a delay that would worsen the emergency, or if a provision of federal law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by an In-Network Participating Practitioner and/or Provider.

If a Participant is admitted to a Non-Participating and/or Out-of-Network Facility, then SHP will contact the admitting Physician to determine Medical Necessity and a plan for treatment. In some cases, where it is medically safe to do so, the Participant may be transferred to an In-Network Participating Facility.

Emergency outside SHP Service Area

If an Emergency Medical Condition occurs when traveling outside of SHP's Service Area, Participants should go to the nearest emergency Facility to receive care. The Participant, or a designated relative or friend, must notify SHP and the Participant's Primary Care Provider and/or Practitioner, if one has been selected, as soon as reasonably possible after receiving treatment for an Emergency Medical Condition, but, no later than forty-eight (48) hours after the Participant is physically or mentally able to do so.

Coverage will be provided for Emergency Conditions outside of the Service Area (at the In-Network benefit level) unless the Participant 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, Participants should contact their Primary Care Provider and/or Practitioner immediately, if one has been selected, and follow his or her instructions. If a Primary Care Provider and/or Practitioner has not been selected, the Participant should contact SHP and follow SHP's instructions. Coverage will be provided for urgent care situations outside the Service Area at the In-Network level unless the Participant has traveled outside the Service Area for the purpose of receiving such treatment.

NOTE: There is no coverage for non-Emergency or non- Urgent Medical Care when traveling outside SHP's Service Area, unless such care is provided by an In-Network Participating Provider. Participant will be responsible to pay 100% of the charges for non-Emergency services received from Non-Participating Providers or Out-of-Network Participating Practitioner and/or Providers.

Not Covered:

- *Emergency care provided outside the Service Area if the need for care could have been foreseen before leaving the Service Area*

Coverage outside of the United States

For emergency services received in a country other than the United States, payment level assumes the provider is Non-Participating. Claims must be submitted in English.

The Health Plan covers worldwide emergency services necessary to screen and stabilize Participants without Prior Authorization in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. Network restrictions do not apply to emergency services received from Practitioners and/or Providers outside of the United States.

Covered services for medically necessary Emergency and Urgent care services received in a foreign country are covered at the In-Network level. There is no coverage for elective (non-emergent or urgent) health care services outside the United States, including when a Participant travels to another country for the purpose of seeking medical treatment outside the United States.

Ambulance and emergency transportation services benefit

Ambulance and emergency transportation services coverage is as follows:

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

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

Certification is required for:

a. Air ambulance services; and
b. Non-emergent transportation.

Not Covered:

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

Section 3(d) Mental health and substance use disorder benefits

IMPORTANT

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

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

IMPORTANT

Benefit Description

Mental health treatment services benefit

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limitations that apply to the 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 includes 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 and/or recurrent); obsessive-compulsive disorders; attention-deficit/hyperactivity disorder; autism spectrum disorder(s); eating 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 Copays, Deductibles, Coinsurance factors, and restrictions as other medical/surgical benefits under the Plan. Coverage for mental health conditions includes:

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

Telephonic consultation for a Participant diagnosed with depression and within twelve (12) weeks of starting antidepressant therapy per Plan guidelines (available upon request). Coverage limited to one (1) telephonic consult per Participant per year for depression and one (1) telephonic consult for Attention-Deficit/Hyperactivity Disorder (ADHD).

NOTE: These benefits are all Admissions or Outpatient Services that require Certification; failure to get Certification will result in a reduction or denial of benefits. *(See Services requiring Certification in Section* 2.):

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

Not Covered:

- *Convalescent care*
- *Marriage or bereavement counseling; pastoral counseling; financial or legal counseling; and custodial care counseling*
- *Educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)*
- *Educational or non-medical services for learning disabilities or behavioral problems*
- *Services related to environmental change*
- *Behavioral therapy, modification, or training that is educational or non-medical in nature; including habilitative services and Applied Behavioral Analysis (ABA)*
- *Milieu therapy*
- *Sensitivity training*
- *Domiciliary care, maintenance care, or Long-Term Residential Care*

Substance use disorder treatment services benefit

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment

limitations that apply to the 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 includes 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 abuse disorder professionals
- Partial Hospitalization
- Intensive Outpatient Programs

NOTE: These benefits are all Admissions or Outpatient Services that require Certification; failure to get Certification will result in a reduction or denial of benefits. *(See Services requiring Certification in Section* 2.):

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

Not Covered:

- *Confinement Services to hold or confine a Participant under chemical influence when no Medically Necessary services are provided, regardless of where the services are received (e.g. detoxification centers)*
- *Marriage or bereavement counseling; pastoral counseling; financial or legal counseling; and custodial care counseling*
- *Educational or non-medical services for learning disabilities*
- *Services related to environmental change*
- *Milieu therapy*
- *Sensitivity training*
- *Domiciliary care or Long-Term Residential Care*
- *Convalescent care*

Section 3(e) Outpatient prescription medication or drug benefits

IMPORTANT

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

- SHP covers prescribed drugs and medications, as described in this Section and in your Summary of Pharmacy Benefits/Formulary.
- All benefits are subject to the definitions, limitations and exclusions in this Summary Plan Description and are payable only when they are Medically Necessary.
- Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.
- **YOU MUST GET PRIOR AUTHORIZATION OF SOME OF THESE SERVICES.** See the benefit description below and your Summary of Pharmacy Benefits/Formulary.

IMPORTANT

Benefit Description

- **Where you can obtain them.** You must fill the prescription at an In-Network Plan Participating pharmacy. If you choose to go to a Non-Participating or Out-of-Network pharmacy, you must pay 100% of the costs of the medication to the pharmacy. Specialty drugs must be obtained through SHP's contracted specialty pharmacy. Please refer to your *Summary of Pharmacy Benefits/Formulary* for a complete listing of specialty drugs that require Prior Authorization.
- **How you can obtain them.** You must present your ID card to your pharmacy, if you do not present your ID card to your pharmacy, you must pay 100% of the costs of the prescription to the pharmacy at the time it is dispensed.
- **We use a formulary.** The Plan covers prescribed drugs and medications according to the applicable formulary listed in your Summary of Pharmacy Benefits/Formulary. A formulary is a list of Prescription Drug Products, which are preferred by the Plan for dispensing to Participants when appropriate. This list is subject to periodic review and modifications. Additional drugs may be added or removed from the formulary throughout the year. SHP will notify you of any changes. For a copy of SHP's formulary, contact Pharmacy Management at (855) 305-5062 | TTY/TDD: (877) 652-1844 *(toll-free)* or you can view the formulary by logging into your account at www.sanfordhealthplan.com/memberlogin.
- **Drug Exclusion.** The Plan reserves the right to maintain a drug listing in which medications are specifically not available for coverage per Plan medical necessity and limitation guidelines. Payment for this list of drugs will be the Participant's responsibility in full. Participants may request a review of an Adverse Determination based on issues of medical necessity as it relates to Non-Covered medications, generic substitution, therapeutic interchanges and step-therapy protocols. For details on this process, see your Summary of Pharmacy Benefits/Formulary.
- **Exception to formulary.** SHP will use appropriate pharmacists and Practitioner and/or Providers to consider exception requests and promptly grant an exception to the drug formulary for a Participant when the health care Practitioner and/or Provider prescribing the drug indicates to SHP that:
  1. The formulary drug(s) causes an adverse reaction in the patient;
  2. The formulary drug(s) is contraindicated for the patient; or
  3. The prescription drug(s) must be dispensed as written to provide maximum medical benefit to the patient.

  NOTE: To request an exception to the formulary, please call Pharmacy Management at (855) 305-5062. Requests for an exception to the formulary can also be faxed to (605) 328-6813 or sent via an online fillable form available by logging into your account at www.sanfordhealthplan.com/memberlogin. If an exception to the formulary 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.

  NOTE: Participants must generally try formulary medications before an exception for the formulary will be made for non-formulary medication use unless a Practitioner and/or Provider determines that use of the formulary drug may cause an adverse reaction to the Participant or may be contraindicated for the Participant.
- **Step Therapy Program.** The step therapy program encourages the use of first-line medications, typically generis, before more expensive second-line medications are covered by the pharmacy benefit. If a Participant does not obtain the desired clinical effect or experiences side effects from a first line medication then the second line medication may be tried. If a step therapy rule is not met at the pharmacy, coverage will be determined by Prior Authorization . You can request Prior Authorization and/or certification by calling Pharmacy Management at (855) 305-5062 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*. Please refer to your *Summary of Pharmacy Benefits/Formulary* for a complete listing of drugs included in SHP's step therapy program.
- **Drugs that Require Prior Authorization.** To be covered by SHP, certain medications need a letter of medical necessity or a formulary exception. This can be in the form of written or verbal certification. To request verbal certification, contact Pharmacy Management at (855) 305-5062 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)* between 8 a.m.-5 p.m. Central Time, Monday through Friday. Written certification may be faxed to Pharmacy Management at (605) 328-6813. Please refer to your *Summary of Pharmacy Benefits/Formulary* for a complete listing of drugs that require Prior Authorization.
- **Drugs that have Quantity Limits.** Certain drugs do not require certification but have a quantity limit to ensure the medication is being used correctly and you are getting the most appropriate treatment based on the manufactures and dosing guidelines. Please refer to your

Summary of Pharmacy Benefits/Formulary for a complete listing of drugs that have a quantity limit on them.

- **There are dispensing limitations.** 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 SHP). Those prescription drug classes identified as maintenance medications will be made available for up to a *ninety (90)* day supply. However, *three (3)* Copays will apply. If you are going 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. Participants are limited to one vacation override per medication per calendar year. Please call SHP for vacation override requests.
- **Prescription Refills**. Prescription refills will be covered when 75% of your prescription has been used based on your prescription. The 75% threshold accumulates the medication used and the previous 180 to determine the date of the next refill.

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

Covered medications and supplies

To be covered by the Plan, drugs must be:

1. Prescribed or approved by a licensed physician, physician assistant, nurse practitioner or dentist;
2. Listed in the Plan Formulary, unless certification is given by the Plan;
3. Provided by an In-Network Participating Pharmacy except in the event of a medical emergency;

NOTE: *If a* prescription *is filled at a Non-Participating and/or Out-of-Network Pharmacy* and *it is not an Emergency, the Participant is responsible for the prescription drug cost in full.*

4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

The following types of drugs are covered, unless **listed in the "*Not Covered*" subsection below under:**

1. **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.
2. **Self-Administered Medications.** Medications that SHP's Pharmacy and Therapeutics Committee has determined do not require professional administration. Medications that require professional administration should be submitted to the Participants medical benefit
3. **Legally Restricted Drugs.** Any medicinal substance that may only be dispensed by a prescription, according to applicable laws and regulations.
4. **Compounded medications.** Compounded medications are any medicinal substance that must be mixed, compounded, or otherwise prepared by a registered pharmacist, and are only covered when such medication has at least one ingredient that is a federal legend or state restricted drug in a therapeutic amount.
5. **Diabetic Supplies/Insulin.** Blood glucose meters, blood glucose test strips, diabetic needles, syringes and injectable insulin. Each of the following shall constitute a separate prescription "supply" for copayment purposes, and together they constitute the maximum amount of diabetic treatment that may be dispensed at any one time *(See section 3(a) for Diabetic supplies, equipment, and self-management training benefits)*:
   a. A thirty (30) day supply of diabetic needles and syringes; and
   b. Diabetic testing strips are limited to two-hundred-five (205) per month, with a written doctor's order.
   c. Blood glucose meters are limited to one (1) meter per calendar year

Contraceptive drugs, supplies, and/or devices. Includes but not limited to contraceptive medications, IUDs, and injectable birth control devices per Plan guidelines. Contraceptives not currently in the Plan Formulary will be covered by the Plan at 100% (no charge) if the Participant's Provider/Practitioner determines that the Non-Formulary contraceptive is medically indicated. If a brand-name contraceptive is prescribed, and no generic equivalent exists, the brand-name contraceptive will be covered by the Plan at 100% (no charge).

Not Covered:

- *Drugs not listed in the SHP Formulary; or without Prior Authorization or a formulary exception from SHP*
- *Replacement of a prescription drug due to loss, damage, or theft*
- *Self-administered medications dispensed in a Provider's office or non-retail pharmacy location*
- *Drugs that may be received without charge under government program, unless coverage is required for the same*
- *Drugs for cosmetic purposes, including baldness, removal of facial hair, and pigmenting or anti-pigmenting of the skin*
- *Refills of any prescription older than one year*
- *Compound medications with no legend (prescription)medication*
- *B-12 injection (except for pernicious anemia)*
- *Drug Efficacy Study Implementation ("DESI")drugs*
- *Experimental and/or Investigational Services not part of an Approved Clinical Trial, unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies*
- *Orthomolecular therapy, including nutrients, vitamins unless otherwise specified as covered in this SPD, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances*
- *Over-the-counter (OTC) Medications, equipment or supplies available (except for insulin, and select diabetic supplies, e.g. syringes,*

needles, test strips and lancets) that by federal law do not require a prescription order;

- *Any medication that is equivalent to an OTC medication except for drugs that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and only when prescribed by a health care Practitioner and/or Provider*
- *Drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law*
- *Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia*
- *Medications that are used to treat infertility*
- *Drugs obtained at a Non-Participating and/or Out-of-Network Pharmacy*
- *Medical Cannabis and its equivalents*
- *Lifestyle Medications (i.e. medications used to treat sexual dysfunction)*
- *Medications that provide little or no evidence of therapeutic advantage of other products available*

Section 3(f) Dental benefits

IMPORTANT

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 Summary Plan Description and are payable only when they are Medically Necessary.
- The Plan covers Hospitalization for dental procedures only when a non-dental physical impairment exists which makes Hospitalization necessary to safeguard the health of the patient. See Section 3(b) for inpatient Hospital benefits. The Plan does 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 PRIOR AUTHORIZATION OF THESE SERVICES.** See the benefits description below.

IMPORTANT

Benefit Description

Dental benefit coverage is as follows:

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

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

Not Covered:

- *Routine or preventive dental care and treatment*
- *Natural teeth replacements including crowns, bridges, braces or implants*
- *Extraction of wisdom teeth*
- *Osseointegrated implant surgery (dental implants)*
- *Hospitalization for extraction of teeth*
- *Removal of wisdom teeth*
- *Dental x-rays oriental appliances*
- *Shortening of the mandible or maxillae for cosmetic purposes*
- *Services and supplies related to ridge augmentation, implantology, and Preventive vestibuloplasty.*
- *Dental appliances of any sort, including but not limited to bridges, braces, and retainers, except for appliances for treatment of TMJ/TMD*

Section 3(g) Out-of-Network Benefit Limitations

IMPORTANT

This Medical Benefit Plan does not cover any Out-of-Network services unless:

- **There is an emergency or urgent care situation; or**
- **Prior Authorization is granted (See Services requiring Certification in Section 2)**

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

IMPORTANT

Benefit Description

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

Services considered Out-of-Network are those:

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

NOTE: When you obtain non-emergency or non-urgent medical treatment from a Non-Participating Practitioner and/or Provider or from an Out-of-Network Participating Provider, without authorization from us, you are responsible for all Out-of-Network charges.

Section 4. Limited and Non-Covered Services

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

General Exclusions

1. Health Care Services provided by a Non-Participating Practitioner and/or Provider or a Participating Practitioner and/or Provider that is not "In-Network" unless there is an Emergency or Urgent Care Situation or Prior Authorization is granted.
2. Health Care Services provided either before the effective date of the Participant's coverage with the Plan, or after the Participant's coverage is terminated
3. Health Care Services performed by any Provider who is a member of the Participant's immediate family, including any person normally residing in the Participant'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 Participant may be treated by that Provider if they are acting within the scope of their practice. The Participant may also go to a Non-Participating and/or Out-of-Network 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 Participant must go to another In-Network Participating Practitioner and/or Provider in order to receive coverage at the In-Network level.
4. Health Care Services Covered By Any Governmental Agency/Unit for military service-related injuries/diseases, unless applicable law requires the Plan to provide coverage for the same
5. 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
6. Health Care Services for sickness or injury sustained in the commission of a criminal act, unless source of injury is a result of domestic violence or a medical condition, whether or not charged or convicted.
7. Health Care Services that the Plan determines are not Medically Necessary
8. Experimental and/or Investigational Services not part of an Approved Clinical Trial, unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies
9. Services that are not Health Care Services
10. Complications from a non-covered procedure or service
11. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner and/or Provider or electronic consultations
12. 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
13. Charges for professional sign language and foreign language interpreter services
14. Charges for duplicating and obtaining medical records from *Non-Participating and/or Out-of-Network Providers* unless requested by SHP
15. Charges for sales tax, mailing, interest and delivery
16. Charges for services determined to be duplicate services by SHP's Chief Medical Officer or designee
17. Charges that exceed the *Maximum Allowed Amount* for Non-Participating and/or Out-of-Network Providers
18. Services to assist in activities of daily living, unless otherwise specified as covered in this Summary Plan Description
19. Alternative treatment therapies including, but not limited to: acupuncture, acupressure, aquatic whirlpool therapy, massage therapy unless covered per Plan guidelines under WHCRA for mastectomy/lymphedema treatment, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, or therapeutic touch
20. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management
21. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics that do not meet Medical Necessity requirements
22. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home
23. The following services or supplies for the treatment of obesity, including but not limited to:
24. Dietary regimen (except as related to covered nutritional counseling as specifically allowed in the Covered Benefits, Section 3, of this Summary Plan Description); and
25. Surgical treatment for reducing or controlling weight (except as specifically allowed in the Covered Benefits, Section 3, of this Summary Plan Description).
26. Services received at bariatric treatment centers;
27. Medical care or prescription drugs (except as specifically allowed in the Covered Benefits, Section 3, of this SPD);
28. Nutritional supplements (services supplies and/or nutritional sustenance products or food not related to enteral feeding when it's the sole means of nutrition);
29. Food supplements;
30. Any services or supplies that involve weight reduction as the main method of treatment (except as specifically allowed in the Covered Benefits, Section 3, of this SPD);
31. Weight loss or exercise programs (except as specifically allowed by the Plan's medical necessity and/or Preventive Health Guidelines, or

in Section 3 of this SPD);
32. Nutritional supplements;
33. Appetite suppressants and supplies of a similar nature; and
34. Services including but not limited to liposuction, gastric balloons, jejunal bypasses and wiring of the jaw
35. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered.
36. Sequela, which are primarily cosmetic that occur secondary to a weight loss procedure (e.g., Panniculectomy, breast reduction or reconstruction)
37. Cosmetic Services and/or supplies to repair or reshape a body structure that are not medically necessary and/or primarily for the improvement of a Participant's appearance, or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services
38. Removal of skintags
39. Food items for medical nutrition therapy (except as specifically allowed in the Covered Benefits Section of this SPD)
40. Any fraudulently billed charges or services received under fraudulent circumstances
41. Autopsies or physical examinations, unless at the request and expense of the Plan, as reasonably necessary while a claim is pending and as permitted bylaw
42. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events that cause 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. Participating Providers are not permitted to bill Participants for services related to such events.
43. Genetic testing except as required by the evidence-based services that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force or those approved by the Chief Medical Officer, per Plan guidelines. *Prior authorization is required.*
44. 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 injuries are not the responsibility of the Participant.
45. Elective health services received outside of the United States
46. Surrogate pregnancies, deliveries, and any related costs for surrogacy
47. Health Care Services ordered by a court or as a condition of parole or probation, unless applicable law requires the Plan to provide primary coverage for the same.
48. Services and coverage listed as "Not Covered" in Section 5, including services beyond the Maximum Benefit Allowance or other service limitation
49. Transplants and pre and post-transplant services at Non-Participating Providers or non-Center Of Excellence Facilities or non-Plan approved facilities
50. Health care services received from a Non-Participating and/or Out-of-Network Provider unless it is an Emergency Situation, Urgent Care Situation, or preauthorized by the Plan
51. Benefits are not available for services listed as "*Not Covered"* in Section 3
52. Charges for injuries or illnesses that commenced prior to your coverage under this Plan, but the cause of which would have otherwise been excluded by thePlan

Services Covered By Other Payors

The following are excluded from coverage:

1. Health services for which other coverage is either (1) required by federal 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 Workers' compensation, no-fault auto insurance, medical payments coverage or similar legislation.

   The Plan is not issued in lieu of nor does it affect any requirements for coverage by Workers' Compensation. This Plan 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 Workers' Compensation or Occupational Disease Act or Law, are excluded from coverage by the Plan. However, if benefits are paid by the Plan and it is determined that the Participant is eligible to receive Workers' Compensation for the same incident; the Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Participant agrees to reimburse the Plan the full amount which the Plan has paid for Health Care Services when entering into a settlement or compromise agreement relating to compensation for the Health Care Services covered by, or at any Workers' Compensation, or as part of any Workers' Compensation Award.

   The Plan reserves its right to recover against Participant even though:
   a. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise; or
   b. No final determination is made that the injury or sickness was sustained in the course of or resulted from employment;
   c. The amount of Workers' Compensation for medical or health care is not agreed upon or defined by Participant or the Workers' Compensation carrier; or
   d. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

Participant will not enter into a compromise or hold harmless agreement relating to any work related claims paid by the Plan, whether or not such claims are disputed by the Workers' Compensation insurer, without the express written agreement of the Plan.

2. Health Care Services received directly from Providers employed by or directly under contract with the Participant's employer, mutual benefit association, labor union, trust, or any similar person or Group.
3. Health Care Services for injury or sickness for which there is other non-Group insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess, or contingent to the Plan. If the benefits subject to this provision are paid for or provided by the Plan, the Plan may exercise its Rights of Subrogation.
4. Health Care Services covered by any governmental health benefit program such as Medicare, Medicaid, and ESRD, unless applicable law requires the Plan to provide coverage for the same. See Section 6, Coordination of Benefits, for details.

Services and payments that are the responsibility of Participant

1. Out-of-pocket costs, including Copays, Deductibles, and Coinsurance are the responsibility of the Participant in accordance with the Summary of Benefits and Coverage, and your Summary of Pharmacy Benefits/Formulary. Additionally, the Participant is responsible to a Provider for payment for Non-Covered Services;
2. Finance charges, late fees, charges for missed appointments and other administrative charges; and
3. Services for which a Participant neither is legally nor as customary practice required to pay in the absence of a group health plan or other coverage arrangement.
4. Services received at the Out-of-Network benefit level. **There is no coverage for health care services received from a Non-Participating and/or Out –of-Network Practitioner and/or Provider other than for an Emergency or Urgent Care Medical Condition.**

Section 5. How Services are paid by the Plan

Reimbursement of Charges by Participating Providers

You will not have to file claims when:

1. you receive services at In-Network, Participating Providers and facilities; or
2. obtain your prescription drugs at In-Network pharmacies. You must present your current identification card and pay your Copay.

When a Participant receives Covered Services from an In-Network Participating Practitioner and/or Provider, SHP will pay the In-Network Participating Practitioner and/or Provider directly, and the Participant will not have to submit claims for payment. The Participant'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 Providers agree to accept either Sanford Health Plan's payment arrangements or the negotiated contract amounts.

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

Charges by Non-Participating Providers

Sanford Health Plan does not have contractual relationships with Out-of-Network and/or Non-Participating Practitioner and/or Providers. Because of this, this SPD does not cover any costs associated with their services. As Participants with no Out-of-Network benefits, any services received Out-of-Network (as defined in Section 3(g)) are the sole responsibility of the Participant.

Claim Submission

You may need to file a claim when you receive emergency or urgent care services from Non-Participating Practitioner and/or Providers. Sometimes these Practitioner and/or Providers submit a claim to SHP 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 SHP within *one hundred eighty (180)* days after the date that the cost was incurred. **If you, or the Non-Participating Practitioner and/or Provider, do not file the claim within *one hundred eighty (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 Participant must give SHP written notice of the costs to be reimbursed. Claim forms are available from Customer Service to aid in this process. Bills and receipts should be itemized and show:

- Participant's name and ID number;
- Name and address of the Physician or Facility that provided the service or supply;
- Dates Participant received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- 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.

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 Participant travels to another country for the purpose of seeking medical treatment outside the United States.

Time Limits. Claims must be submitted to SHP within *one hundred eighty (180)* days after the date that the cost was incurred. If you, or the Non-Participating Practitioner and/or Provider, file the claim after the one hundred eighty (180) timely filing limit has expired, you will be responsible for payment ofthe claim.

Submit your claims to: SHP, PO Box 91110, Sioux Falls, SD 57109-1110

Timeframe for Payment of Claims

The payment for reimbursement of the Participant's costs will be made within thirty (30) days of when Sanford Health Plan receives a complete claim with all required supporting information.

When a Participant receives Emergency or Urgent Care Services from an Out-of-Network and/or Non-Participating Practitioner and/or Providers and payment is to be made according to Plan guidelines, Sanford Health Plan will arrange for direct payment to either the Out-of-Network and/or Non-Participating Practitioner and/or Providers, or the Participant, per Plan policies.

If the Provider refuses direct payment, the Participant will be reimbursed for the Maximum Allowed Amount of the services in accordance with the terms of this Plan and this Summary Plan Description. The Participant will be responsible for any expenses that exceed the Maximum Allowed Amount, as well as any Copay, Deductible, or Coinsurance, which is required for the Covered Service.

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 (COB)

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

Coordination of Benefits (COB) sets out rules for the order of payment of Covered Charges when two or more plans, including Medicare/Medicaid/TRICARE, are paying. When a Covered Individual is covered by this Plan and one or more other plans, the plans will coordinate benefits when a Claim is received. The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to one hundred (100%) percent of the total Allowable Charge

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

1. The Participant must tell the Plan about any other plans or insurance that cover health care for the Participant, and
2. The Participant must cooperate with the Plan by providing any information requested by SHP.

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

NOTE: This section does not apply to Outpatient Prescription Drug Benefits.

Applicability

The Coordination of Benefits (COB) provision, under this Summary Plan Description, applies to this Plan when a Participant or Participant's covered Dependent 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:

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

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 Plan Sponsor. 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.

Some, or all, of the costs of medical care are may be the responsibility of an insurance party other than the Plan Sponsor, if the Participant is injured, or become ill, as a result of work-related accidents or environment, and is eligible for benefits under applicable Workers' Compensation Laws. If Workers' Compensation denies all or part of a claim, SHP will review the claim to determine whether to pay any benefits as the secondary carrier.

Excess Insurance

If at the time of injury, illness, disease, or disability there is available, or potentially available any Coverage (including Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits will be excess to, whenever possible:

a. Any primary payer besides the Plan;
b. Any first party insurance through medical payment coverage, personal injury protection, No-fault Auto Insurance coverage, uninsured or underinsured motorist coverage;
c. Any policy of insurance from any insurance company or guarantor of a third party;
d. Workers 'Compensation or other liability insurance company; or
e. Any other source, including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Excess insurance is also discussed in Section 7.

Allowable Charge/Expense

For a charge to be "allowable" it must not exceed the Usual and Customary Rate and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other In-Network only plans: This Plan will not consider any charges in excess of what an HMO or network Health Care Provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Individual does not use an HMO or network Health Care Provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Individual used the services of an HMO or network Health Care Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge. See definition of "Allowable Expense" below for further information on this provision.

Automobile Insurance Limitations

When medical payments are available under any vehicle insurance (including no-fault automobile insurance, uninsured motorist coverage, or underinsured motorist coverage), the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles.

This Plan shall always be considered secondary to any such vehicle plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification.

Definitions (for COB Purposes Only)

1. **"Plan"** is any of the following which provides benefits or services for, or because of the benefits of another medical or dental care or treatment plan:
   a. Group insurance or 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. 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.
2. "**This Plan**" refers to this Plan, which provides benefits for health care expenses.
3. "**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 Participant 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 Participant, 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.
4. **"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.
   a. 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.
   b. An expense or service, or a portion of an expense or service, which is not covered by any of the plans, is not an allowable expense. Expenses not allowable include the following:
      i. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room (unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined by SHP) is not an allowable expense;
   a. An expense or service, or a portion of an expense or service, which is not covered by any of the plans, is not an allowable expense. Expenses not allowable include the following:
      ii. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room (unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined by Sanford Health Plan) is not an allowable expense;
      iii. If a person is covered by two or more plans (excluding Medicare, Medicaid, or TRICARE; see "*Coordination of Benefits with Governmental Plans*" 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;
      iv. If a person is covered by two or more plans (excluding Medicare, Medicaid, or TRICARE; see "*Coordination of Benefits with Governmental Plans*" 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;
      v. 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
      vi. When benefits are reduced under a primary plan because a Participant 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, Prior Authorization of admissions, or because the person has a lower benefit because the person did not use a preferred Practitioner and/or Provider.
5. **"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.
6. "**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 overinsurance 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.
7. **"Closed Panel Plan"** is a plan that provides health benefits to Participants 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.
8. **"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.

Order of Benefit Determination Rules

1. **General**. When two or more plans pay benefits, the following rules apply when determining which health plan will be the primary payer:
   a. Any plan without a COB provision always pays first.
   b. Plans with COB provisions will pay their benefits up to the Allowable Charge/Expense, as defined in this Section.
   c. If a Covered Individual is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
2. The Plan will pay primary to TRICARE and a State child health plan to the extent required by federal law.
3. **Rules**. This Plan determines its order of benefits using the first of the following rules which applies:
   a. **Non-Dependent/Dependent**. The plan which covers the person as a Participant, (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:
      i. Secondary to the Plan covering the person as a Dependent; and
      ii. Primary to the Plan covering the person as other than a Dependent, for example a retired Participant, then the order of benefits between the two plans is reversed so that the plan covering the person as a Participant is secondary and the other plan is primary.
   b. **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:
      i. The plan of the Participant covering the child whose birthday occurs earlier in the calendar year will be primary (known as *the birthday rule*).
         (1) If both have the same birthday, the policy that has been in effect longer will be primary.
         (2) The birthday rule is superseded when a court order or custody rule applies.
      ii. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
      iii. 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.
      iv. If the parents are not married, or are separated (whether or not they have been married) or are divorced, the order of benefits is:
         (1) The plan ofthe custodial parent;
         (2) The plan of the Spouse of the custodial parent;
         (3) The plan of the noncustodial parent; and then
         (4) The plan of the Spouse of the noncustodial parent.
   c. If the dependent is a child of divorced or separated parents, primary payer status is determined according to the following:
      i. If the divorce decree places responsibility on one parent, that parent's health plan is primary.
      ii. Otherwise, the custodial parent's plan is primary and the other parent's health plan becomes secondary.
      iii. If there is joint custody, the *Birthday Rule* applies and the health plan of the parent whose birthday occurs earlier in the calendar year is primary.
   d. **Active/Inactive Participant**. The benefit of a plan that covers a person as a Participant who is neither laid off nor retired (or as that Participant's Dependent), is primary. If the other plan does not have this rule, and if as a result, the plans do not agree on the order in which benefits are payable, this rule is ignored. Coverage provided to an individual as a retired worker and as a Dependent of an actively working Spouse will be determined under the rules above. The benefits of a benefit plan that covers a person as a non-COBRAbeneficiary are determined before those of a plan that covers the person as a COBRAbeneficiary.
   e. **Continuation Coverage**. If a person, whose coverage is provided under a right of continuation, pursuant to a federal is also covered under another plan, the following shall be the order of benefit determination:
      i. Primary, the benefits of a plan covering the person as a Participant (or as that person's Dependent);
      ii. Secondary, the benefits under the continuation coverage. If none of the above rules determines the order of benefits, the benefits of the plan that covered the Participant longer, is primary.
   f. **Longer or shorter length of Coverage.** The plan that covered the person as an Employee, Participant, Dependent, or retiree longer is primary.

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

Effect of COB on the Benefits of this Plan

1. **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" below.
2. **Reduction in this Plan's Benefits**. The benefits of this Plan will be reduced when the sum of:
   a. the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
   b. 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 the benefits that would have been paid for the Participant under this Plan.

c. If a Participant 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.

d. 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.

3. **Plan's Right to Receive and Release Needed Information**. Certain facts are needed to apply these COB rules. SHP has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. SHP need not tell, or get the consent of any person to do this. Each person claiming benefits under this Plan must give SHP any facts it needs to pay the claim.
4. **Facility of Payment**. Payment made under another plan may include an amount that should have been paid under this Plan. If it does, SHP 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. SHP 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.
5. **Right of Recovery**. If the amount of the payments made by SHP is more than it should have paid under this COB provision, it may recover the excess from one or more of:
   a. The persons it has paid or for whom it has paid;
   b. Insurance companies; or
   c. Other organizations.

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

Calculation of Benefits, Secondary Plan

If this 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 oftotal allowable expenses.

In determining the amount of a claim to be paid by the Plan, should the Plan wish to coordinate benefits, it shall calculate the benefits the Plan 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 primaryplan.

The Plan may reduce the Plan payment by any amount that, when combined with the amount paid by the primary plan, exceeds the allowable expense the Plan would have paid for thatclaim.

Coordination of Benefits with Governmental Plans

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

Coordination of Benefits with Medicare

1. The federal "Medicare Secondary Payer" (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account when:
   a. determining whether these individuals are eligible to participate in the Plan; or
   b. providing benefits under the Plan.
2. Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, this 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. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Claims Administrator 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 Participant has health coverage under this Plan and is eligible for insurance under Medicare, Parts A and B, (whether or not the Participant has applied or is enrolled in Medicare). This provision applies before any other Coordination of Benefits Provision of this Plan.

Coordination with Medicare Part D

This Plan 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 this Plan's COB with Medicare:

1. When Medicare is the primary payer for a Participant's claims:
   a. If you're 65, or older, and have group health plan coverage based on your or your spouse's current employment
   b. 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 patient 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 Participant 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.

2. When Medicare is primary despite the MSP rules:
   a. A Medicare-entitled person refuses coverage under this Plan;*****
   b. Medical services or supplies are covered by Medicare but are excluded under the group health plan;
   c. A Medicare-entitled person has exhausted his or her benefits under the group health plan;
   d. A person entitled to Medicare for any reason other than ESRD, experiences a COBRA qualifying event, and elects COBRA continuation;
   e. A person who was on COBRA becomes entitled to Medicare for a reason other than ESRD, and his or her COBRA coverage ends.

   *** NOTE:** *Despite the MSP rules, the law does not force an Eligible Employee to accept coverage under this Plan. If an Eligible Employee, who is entitled to Medicare, refuses coverage under this Plan, Medicare will be the primary payer. In this situation, the Plan does not (and is not allowed to) provide coverage for any benefits to supplement the individual's Medicare benefits.*
3. When the Plan is the primary payer for a Participant's claims:
   a. If you're under 65 and disabled, and have coverage under this Plan based on your or a family member's current employment
   b. When coverage under the Plan is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA)
   c. The Participant (actively-working Employee) is enrolled in Medicare because they are age 65 or older.
   d. A Covered Spouse, who is enrolled in Medicare because they are age 65 or older, regardless of the age of the Participant/Employee.

   NOTE: The Participant's claim is filed with us by the hospital or doctor. After the claim is processed, we send the Participant an Explanation of Benefits (EOB) outlining the charges that were covered. We also notify the health care professionals of the covered charges. If there are remaining charges covered by Medicare, the health care professional may file a claim with Medicare. If the professional will not do so, the Participant can file the claim with Medicare. Participants 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).
4. If a Practitioner and/or Provider has accepted assignment of Medicare, the Plan determines allowable expenses based upon the amount allowed by Medicare. The Plan's allowable expense is the Medicare allowable amount. The Plan pays the difference between what Medicare pays and SHP's allowableexpense.
5. Employees who reach age 65 and are still employed at Sanford may remain covered under the Sanford Health Plan. Sanford Health Plan will remain the primary carrier and Medicare will be the secondary carrier. When the Spouse of an Employee reaches the age of 65, they will have the option of selecting Sanford Health Plan or Medicare as their primary insurance carrier.

Participants 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.

The 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:

a. When the Plan is the primary payer for a Participant's claims under ESRD:
a. The Plan will pay first for the first 30 months after you become eligible to join Medicare.
b. During the Medicare coordination period of thirty (30) months, which begins with the earlier of:
   i. The month in which a regular course of renal dialysis is initiated; or
   ii. In the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.
   iii. The Medicare COB period applies regardless of whether coverage under the Plan is based on current employment status.
c. After the 30-month period, if a Participant does not enroll in, or is no longer eligible for, Medicare.
d. When coverage under the Plan is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA), or a retirement plan.
b. When Medicare is the primary payer for a Participant's claims under ESRD:
a. If the Participant is eligible and enrolled in Medicare, Medicare will pay first after the coordination period for ESRD (30-months) has ended period.

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 the Plan will honor any subrogation rights the State may have with respect to benefits that are payable under the Plan.

When an individual covered by Medicaid also has coverage under this Plan, Medicaid is the payer of last resort. If also covered under Medicare, this Plan pays primary, then Medicare, and Medicaid is tertiary.

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

Coordination of Benefits with TRICARE

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

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

The Plan Sponsor, and its delegated Claims Administrator, SHP, do not:

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

Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan. If Medicaid covers a Participant and Medicaid pays benefits that should have paid by this Plan, this Plan will pay those benefits directly to Medicaid.

Right of Recovery

Whenever payments have been made by this Plan with respect to Allowable Charges in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine:

1. Any person to or with respect to whom such payments were made, or such person's legal representative;
2. Any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Charges; and
3. Any future benefits payable to the Covered Individual.

Section 7. Subrogation and Right of Reimbursement

If a Participant is injured or becomes ill because of an action or omission of a third party who is or may be liable to the Participant for the injury or illness, the be able to "step into the shoes" of the Participant to recover health care costs from the party responsible for the injury or illness. This is called "Subrogation," and this part of the SPD covers such situations.

This Plan may give or obtain needed information from another insurer or any other organization or person. Each and every Covered Individual hereby authorizes the 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.

The Health Plan has a right to reduce benefits, or to be reimbursed for that which it has provided to the Participant. This is called "Reimbursement" and this part of the SPD covers such situations.

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

Plan's Rights of Subrogation and Reimbursement

In the event of any payments for benefits provided to a Participant under this Plan, the Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Participant, Participant'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.

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

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

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

As assignee, the Plan shall recover the first dollar you or your dependent is entitled to receive from any source for you of your dependent's injury(ies) or Illness(es) up to the amount advanced, regardless of whether you or your dependent is made whole, regardless of whether you or your dependent has been paid for all of his or her claims for damages, and regardless of how the payment is described. The made whole doctrine shall not apply to the Plan's right of assignment. The Plan's right of assignment is a right of first reimbursement and takes priority over any person's interest in such payment. As a result, the Plan shall automatically have a first priority lien upon the proceeds of any recovery you or your dependent receive(s). The Plan's right of assignment shall not be reduced by any attorney's fees, court costs, or other expenses incurred by you or your dependent to recover such payments. If the Plan is precluded from exercising its right of assignment, the Plan may exercise its right of subrogation and/or reimbursement as stated below.

If payments are made under this Plan for any treatment or service because of injury to, or sickness of, a covered individual who has a lawful claim, demand or right against a third party or parties (including an insurance carrier or uninsured motorist coverage) for indemnification, damages or other payment with respect to such injury or sickness, then:

a. The Plan shall be subrogated, to the extent of the payments made under this Plan, to the rights of the covered individual to receive or claim such indemnification, damages or other payment.
b. The covered individual and their legal counsel, if any, shall execute or secure the execution of such instruments as the Plan may reasonably require to enforce its rights hereunder; and
c. Any individual who shall receive payment from any such third party or parties because of injury to, or sickness of, a covered individual shall first reimburse the Plan (before reimbursing any third parties) from such payment so received (but not in excess of the amount received) for all payments made, past, present, and future under this Plan for treatment or service with respect to the same injury or sickness.
d. Such first reimbursement shall be made to the Plan, without set-off for attorney fees or any other costs or expenses and without regard to whether the covered individual has been "made whole" for his/her damages and the Plan shall hold an automatic first priority lien upon the proceeds of any reimbursement payment or recovery until it receives full reimbursement.
e. Should the covered individual fail to reimburse the Plan first from any such payment received, the Plan may file suit to recover, and the covered individual will be solely responsible for any court costs in connection with such suit.

The Participant is required to submit a Subrogation Agreement provided by the Plan office which has been signed by the Participant, beneficiary if applicable, and their legal counsel, if any, as a necessary part of Proof of Loss for a claim involving a third party action. Failure to submit such signed agreement may cause payment of the claim to be delayed until the third party action is resolved or disallowed due to failure on the part of the Participant to provide adequate Proof of Loss. The payment of benefits by the Plan without a Subrogation Agreement shall not diminish or nullify the Plan's rights of subrogation and/or reimbursement.

Under no circumstances will the Plan share in or assume liability for any legal fees or any other costs and expenses incurred by the covered individual in connection with any third party claim, and its rights of Subrogation and First Reimbursement shall not be subject to the "Make Whole" doctrine, or similar doctrine, under state law or federal common law.

If you or your dependent recovers from any source any amount for any injury(ies) or Illness(es) for which the Plan advanced medical payments, you or your dependent shall reimburse the Plan an amount equal to the amount advanced or the amount of you or your dependent's recovery, whichever is lesser. The Plan shall recover the first dollar you or your dependent is entitled to receive from any source for you or your dependent's injury(ies) or Illness(es), regardless of whether you or your dependent is made whole, regardless of whether you or your dependent has been paid for all of his or her claims for damages, and regardless of how the payment is described. The make whole doctrine shall not apply to the Plan's right of reimbursement.

The Plan's right of reimbursement is a right of first reimbursement and takes priority over any person's interest in such payment. As a result, the Plan shall automatically have a first priority lien upon the proceeds of any recovery you or your dependent receive(s). The Plan's right of reimbursement shall not be reduced by any attorney's fees, court costs, or other expenses incurred by you or your dependent to recover such payments. If the Plan is precluded from exercising our right of reimbursement, the Plan may exercise our right of assignment and/or subrogation.

Plan's Right to Reduction and Reimbursement

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

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

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

Erroneous Payments

To the extent payments made by this Plan with respect to a Covered Individual are in excess of the Maximum Amount of payment necessary under the terms of the Plan, the 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 the Plan determines are either responsible for payment or received payment in error, and any future benefits payable to the Covered Individual.

Participant's Responsibilities

1. The Participant, Participant's parents, heirs, guardians, executors, or other representatives must take such action, furnish such information and assistance, and execute such instruments as the Plan requires to facilitate enforcement of its rights under this Part. The Participant shall take no action prejudicing the rights and interests of the Plan under this provision.
2. Neither a Participant nor Participant's attorney or other representative is authorized to accept subrogation or reimbursement payments on behalf of the Plan, to negotiate or compromise the Plan's subrogation or reimbursement claim, or to release any right of recovery or reimbursement without the Plan's express written consent.
3. Any Participant who fails to cooperate in the Plan's administration of this Part shall be responsible for the Maximum Allowed Amount for services subject to this section and any legal costs incurred by the Plan to enforce its rights under this section. The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Individual if a Covered Individual refuses to cooperate with the Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Covered Individual is a minor, the 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 the 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. The Plan Administrator reserves the right to terminate an individual's eligibility for coverage under this Plan if the individual fails to cooperate.
4. Participants 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 Participant paid for by the Plan. Failure to comply will entitle the Plan to withhold benefits, services, payments, or credits due under the Plan.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Individual(s), and funds held in trust over which the 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 the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Section 8. How coverage ends

Termination of Participant Coverage

Participant, retiree, or Dependent's coverage will automatically terminate at the earliest of the following events below. Such action is called "Termination" of the Participant.

1. **Premium Payments**. Failure to make premium payments when due.
2. **Employee Termination.** Your benefits will end upon expiration of the period covered by your last contribution.
3. **Plan Termination**. The date this Plan terminates.
4. **Eligibility**. Your benefits will end upon expiration of the period covered by your last contribution.
5. **Dependent Eligibility**. Benefits for your dependents will end upon expiration of the period covered by your last contribution.
6. **Retiree Termination.** The last day of the month in which the retiree, or his or her Dependents, become eligible for Medicare.
7. **Divorce/Legal Separation.** Coverage for a Dependent Spouse will end on the last day of the month in which the date of divorce or legal separation occurs.
8. **Death.** The date the Participant dies.
9. **Intentional Misrepresentation, Concealment of Material Fact or Fraudulent Information**. If your coverage is terminated for these reasons, the Plan Administrator will provide at least thirty (30) days' written notice before the effective date of Rescission to each Participant affected when the Plan determines a Participant has engaged in fraud or made an intentional misrepresentation of material fact under this Summary Plan Description.
10. **Use of ID Card by Another**. The date a Participant allows another individual to use his or her ID card to obtain services.

Participant Appeal of Termination

Participant may appeal the Plan's decision to terminate, cancel, or refuse to renew the Participant's coverage. The appeal will be considered to be a Participant Appeal under the Plan Sponsor's policy on Participant Appeals, which will govern the Appeal procedure.

Pending the appeal decision, coverage will terminate on the date that was set by the Plan Sponsor. However, the Participant may continue coverage, if entitled to do so, by complying with the process to continue coverage, as outlined in Section 10. If the Plan Sponsor decides the appeal in favor of the Participant, coverage will be reinstated, retroactive to the effective date of termination, as if there had been no lapse in coverage.

NOTE: A Participant may not be terminated due to the status of the Participant's health or because the Participant has exercised his or her rights under the Plan Sponsor's policy on participant appeals or the policy on appeal procedures for medical review determinations.

Continuation of Coverage for Confined Participants

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

Cancellation of This or Previous Benefit Plans

If the Benefit Plan is terminated, modified or amended, coverage is automatically terminated, modified or amended for all enrolled Participants of the Plan. It is the Plan Administrator's responsibility to notify Participants of the termination of coverage.

Notice of Creditable Coverage

You, the Participant, may request a Certificate of Creditable Coverage for you and your covered family Participants upon your voluntary or involuntary termination from the Plan. You may also request a Certificate of Creditable Coverage at any time by calling Customer Service toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844 *(toll-free)*.

Written requests may be sent to:
Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110

Section 9. Options after Coverage Ends

Federal Continuation of Coverage Provisions ("COBRA")

Notice of Continuation Coverage Rights Under COBRA

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it. When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify SHP of the following qualifying events:

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

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

to your employer or contact SHP's Customer Service at (800) 752-5863 *(toll-free)* | TTY/TDD (877) 652-1844 *(toll-free)*.

How is COBRA Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

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

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

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

Are there other coverage options besides COBRA Continuation Coverage?

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

If You Have Questions

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

Keep Your Plan Informed of Address Changes

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

Claims Administration Contact Information

Mail: Sanford Health Plan, Customer Service, 300 Cherapa Place, Suite 201, Sioux Falls, SD 57103.
Phone: (800) 752-5863 *(toll-free)*
TTY/TDD: (877) 652-1844 *(toll-free)*
Fax: (605) 328-6812

The Family Medical Leave Act of 1993 (FMLA)

If applicable, FMLA requires covered employers to provide up to *twelve (12)* weeks of unpaid, job-protected leave to "eligible" Employees for certain family and medical reasons. FMLA also allows an Employee to take up to a total of twenty-six (26) weeks to care for a Spouse, parent, child or "next of kin" who has suffered a serious illness or injury while on active military duty. Employees are eligible if they have worked for a covered employer for at least one (1) year and for 1,250 hours over the previous twelve (12) months, and if there are at least fifty (50) Employees within seventy-five (75) miles. If you are eligible for FMLA leave, you may continue coverage under the Plan by paying employee premiums.

The Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA)

CONTINUATION OF BENEFITS

Effective October 13, 1994 federal law requires that health plans offer to continue coverage for Employees who are absent due to service in the uniformed services and/or their Dependents. Coverage may continue for up to twenty-four (24) months after the date the Employee is first

absent due to uniformed service.

ELIGIBILITY

An Employee is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary service, in time of peace or war. USERRA applies to people in the active components of the following uniformed services: Army, Navy, Air Force, Coast Guard and Marine Corps and their reserves; Army and Air National Guards; the commissioned corps of the Public Health Service; and certain types of service in the National Disaster Medical System. Service includes absence for active duty, active or inactive duty for training, initial active duty for training, full-time National Guard duty, examination to determine fitness for duty, funeral honors duty by National Guard or Reserve members; and certain duties performed by National Disaster Medical System Employees.

An Employee's Dependents who have coverage under the Plan immediately prior to the date of the Employee's covered absence are eligible to elect continuation under USERRA.

PREMIUM PAYMENT

If continuation of Plan coverage is elected under USERRA, the Employee or Dependent is responsible for payment of the applicable cost of coverage. If the Employee is absent for no longer than thirty-one (31) days, the cost will be the amount the Employee would otherwise pay for coverage. For absences exceeding thirty-one (31) days, the cost may be up to 102% of the cost of the full premium under the Plan. This includes the Employees share and any portion previously paid by the employer.

DURATION OF COVERAGE

Elected continuation coverage under USERRA will continue for a period that is the shorter of the following two periods:

- Twenty-four (24) months beginning the first day of absence from employment due to service; or
- The period beginning on the date the Employee's absence begins and ending on the date on which the Employee fails to return to the job or apply for reemployment as required by USERRA.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an Employee and/or eligible Dependents. When the Employee returns to work and meets the reinstatement eligibility criteria as defined by USERRA, the Plan will waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation.

OTHER INFORMATION

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or a change of address.

Section 10. Problem Resolution

Participant Appeal and Complaint Procedures – OVERVIEW

SHP 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 Plan will be paid only if SHP decides, at SHP's discretion, that the applicant is entitled to them.

Claims for benefits under the Plan 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 the Plan; or appeal a partial or complete denial of a claim. The appeal procedures outlined below are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

For information on medication/drug formulary exception requests, see Section 2, subsection "*Pharmaceutical Review Requests and Exception to the Formulary Process.*

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

NOTE: The Participant or his/her legal guardian may designate in writing to SHP an Authorized Representative to act on his/her behalf. In cases where the Participant wishes to exercise this right, a written designation of representation from the Participant should accompany a Participant'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 Participants who request language services, the Plan will provide services at no charge in the requested language through an interpreter. Translated documents are also available at no charge to help Participants submit a complaint or appeal, and SHP will communicate with Participants free of charge about their complaint or appeal in the Participant's preferred language, upon request. To get help in a language other than English, call (800) 892-0625.

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

To contact SHP, a TTY/TDD line is available free of charge by calling toll-free (877) 652-1844.

Designating an Authorized Representative.

You must act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. If you wish to designate an Authorized Representative, you must do so in writing. You can get a form by calling Customer Service toll-free at (800) 752-5863; or logging into your account at www.sanfordhealthplan.com/memberlogin. If a person is not properly designated in writing as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Summary Plan Description.

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

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) that is based on:

1. A determination of an individual's eligibility to participate in the Plan;
2. A determination that a benefit is not a Covered Benefit;
3. The imposition of an exclusion, including a 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 coverage; and deny claims.

Appeal: A request to change a previous Adverse Determination made by SHP.

Inquiry: An oral communication regarding eligibility, plan interpretation, plan policies and procedures, or plan design. It is the policy of SHP to address Participant and Practitioner and/or Provider inquiries through informal resolution orally, 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 an oral or written Complaint.

Complaint (Grievance): Any expression, written or oral, regarding dissatisfaction in how SHP operated or administered services. It is the policy of SHP to make reasonable efforts to resolve Participant and/or Practitioner and/or Provider Complaints. A process has been established for Participants (or their designees) and Practitioners and/or Providers to use when they are dissatisfied with SHP, its Practitioners and/or Providers, or processes. Examples of Complaints are eligibility issues; coverage denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services provided.

Complainant: This is a Participant, applicant, or former Participant or anyone acting on behalf of a Participant, applicant, or former Participant, who submits a Complaint. The Participant and his/her legal guardian may designate in writing to SHP an Authorized Representative to act on his/her behalf. This written designation of representation from the Participant 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 through its External Appeals process.

Urgent Care Situation: A degree of illness or injury, which is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours.

Urgent Care Request: 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:

1. Seriously jeopardize the life or health of the Participant or the ability of the Participant 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 Participant's medical condition, subject the Participant 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," SHP shall apply the judgment of a Prudent Layperson as defined in Section 11. A request from a Physician with knowledge of the Participant's medical condition, who determines a request to be "urgent" as defined in Section 11, shall have such a request treated as an Urgent Care Request.

Complaint (Grievance) Procedures

A Participant has the right to file a Complaint either orally or in writing with Customer Service. Customer Service will make every effort to investigate and resolve all Complaints. Customer Service may be reached toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844, 8:00 am to 5:00 pm, Central Time, Monday through Friday.

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

Oral Complaints

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

Written Complaints

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

Sanford Health Plan
Customer Service
PO Box 91110
Sioux Falls, SD 57109-1110
or Fax: (605) 328-6812

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

Customer Service will notify the Complainant within *ten (10) business days* of receiving a written Complaint, unless the Complaint has been resolved to the Complainant's satisfaction within those *ten (10) business days.*

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

Written Complaint Investigations

Customer Service will investigate and review the Complaint and notify the complainant of SHP's decision in accordance with the following timelines:

1. A decision and written notification on the Complaint will be made to the complainant, his or her Practitioners and/or Providers involved in the provision of the service within *thirty (30) calendar days* from the date SHP receives your request.
2. In certain circumstances, the time period may be extended by up to *fourteen (14) days* upon agreement. In such cases, SHP will notify the complainant in advance, of the reasons for the extension.
3. Any complaints related to the quality of care received are subject to practitioner review. If the complaint is related to an urgent clinical matter, it will be handled in an expedited manner, and a response will be provided within *seventy-two (72) hours*.

Unresolved Complaints (Grievances)

If a Complaint is not resolved to the Participant's satisfaction, the Participant, or his/her Authorized Representative, has the right to Appeal any adverse determination made by SHP. Appeal Rights may be requested by calling Customer Service toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844, 8:00 am to 5:00 pm, Central Time, Monday through Friday. To contact SHP in a language other than English, call (800) 892-0625 *(toll-free)*. Language assistance services are free of charge.

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

Appeal Procedures

Types of Appeals

- A **Pre-Service Appeal** is a request to change an Adverse Determination that SHP denied, in whole or in part, in advance of the Participant obtaining care or services.
- A **Post-Service Appeal** is a request to change an Adverse Determination for care or services already received by the Participant.
- An **Expedited (Urgent) Appeal** is a request to change a previous Adverse Determination made by SHP when services subject to the request are of an urgent or emergent nature.

Continued Coverage for Concurrent Care

A Participant 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.

Internal Appeal of Adverse Determination (Denial)

Filing Deadline

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

To Appeal an Adverse Determination

The Participant, or the Authorized Representative, should contact SHP by calling or sending a written Appeal (using the *Appeal Filing Form* is optional) to the following address:

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

You may also Appeal by calling (800) 752-5863 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)*; or faxing (605) 328-6812 *(long-distance charges may apply).*

Written Notification Process for Internal Appeals

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

1. The results and date of the Appeal Determination;
2. The specific reason for the Adverse Determination decision in easily understandable language;
3. The titles and qualifications, including specialty, of the person or persons participating in the internal 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 Participant on request can have a copy of the actual benefit provisions, guidelines, and protocols free of charge;
5. Notification the Participant can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Participant's benefit request;
6. Statement of the reviewer's understanding of the Participant's Appeal;
7. The Reviewer's decision in clear terms and the Summary Plan Description benefit plan basis or medical rationale in sufficient detail for the Participant to respond further;
8. Notification and instructions on how the Practitioner and/or Provider can contact the Physician and/or appropriate Practitioner to discuss the determination;
9. If the Adverse Determination is based on a Medical Necessity, Experimental or Investigational treatment, or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the Plan to the Participant's medical circumstances; or a statement that an explanation will be provided to the Participant free of charge, upon request;
10. If applicable, instructions for requesting:
    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) Appeals,** a statement indicating:
    a. The written procedures governing the standard internal appeal, including any required timeframes for receipt of information and SHP's determination; and
    b. The Participant's right to bring a civil action in a court of competent jurisdiction.
12. A description of a Participant's right to bring civil action under §502(a) of ERISA; and

13. If the Adverse Determination is completely overturned by the appeal, the decision notice will state the decision and the date.

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

If the Participant or a Participant's authorized representative (as designated in writing by the Participant) files an Appeal for an Adverse Determination, the following Appeal Rights apply:

1. The Participant shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. Participants do not have the right to attend or have a representative attend the review.
2. The Participant shall be provided, free of charge, any new or additional evidence considered, relied upon, or either generated by or at the direction of SHP, 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 Participant a reasonable opportunity to respond prior to that date.
3. Confirm with the Participant whether additional information will be provided for appeal review. SHP will document if additional information is provided or no new information is provided for appeal review.
4. Before SHP issues a final Adverse Determination based on any new or additional rationale, the Participant 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 Participant a reasonable opportunity to respond prior to the date.
5. The Participant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's initial request.
6. The review shall take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
7. Full and thorough investigation of the substance of the Appeal, including any aspects of clinical care involved, will be coordinated by the department supervisor.
8. SHP will document the substance of the Appeal, including but not limited to, the Participant's reason for appealing the previous decision and additional clinical or other information provided with the appeal request. SHP will also document any actions taken, including but not limited to, previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal.
9. The review shall not afford deference to the initial Adverse Determination; and shall be conducted by a named Plan representative who is neither the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual.
10. In deciding an appeal of any Adverse Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational, or not Medically Necessary or appropriate, SHP shall consult with a health care professional (same-or-similar specialist) who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care Practitioner and/or Provider engaged for purposes of a consultation under this paragraph shall be an individual who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.
11. SHP shall identify the medical or vocational experts whose advice was obtained on behalf of SHP in connection with a Participant's Adverse Determination, without regard to whether the advice was relied upon in making the benefit request determination.
12. In order to ensure the independence and impartiality of the persons involved in making claims determinations and appeals decisions, all decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.
13. The attending Practitioner and/or Provider, and the Participant, will be made aware of their responsibility for submitting any documentation required for resolution of the Appeal within three (3) business (working) days of SHP's request upon receipt of the Appeal.
14. SHP will provide notice of any Adverse Determination in a manner consistent with applicable federal regulations.
15. If the Appeal determination is adverse, the Participant shall be informed of their right to file a civil suit in a court of competent jurisdiction upon completion of the Plan's Appeal procedures.
16. If SHP fails to provide adequate notification of a benefit determination, the 180 day limitation to file an appeal does not apply. If such situation occurs, a Participant should file an Appeal as soon as reasonably possible and the right to file a suit in federal court is not bound by the 180-day filing limitation.

Standard (Non-Urgent) Appeal Notification Timelines

For Pre-service Claim (Prospective) Appeals: SHP will notify the Participant or their Authorized Representative, and any Practitioner and/or Providers involved in the appeal, in writing or electronically of SHP's Internal Appeal determination within thirty (30) calendar days of receipt of Appeal. For initial determination request timelines, see Section 2, *How you get care.*

For Post-service Claim Appeals: SHP will notify the Participant or their Authorized Representative, and any Practitioner and/or Providers involved in the appeal, in writing or electronically of SHP's Internal Appeal determination within sixty (60) calendar days of receipt of Appeal. For initial determination request timelines, see Section 2, *How you get care.*

Expedited (Urgent) Appeal Procedure

The procedures in this Section are used for an **Expedited (Urgent) Appeal**, which is when the Participant's condition is urgent or emergent and an *Urgent Care Request* is being appealed, as defined in Section 11 of this Summary Plan Description.

An **Expedited (Urgent) Appeal** for **Pre-service or Concurrent** claims are utilized if the Participant, or Practitioner and/or Provider acting

on behalf of the Participant, believes that an Expedited (Urgent) Appeal is warranted. As described in this Section and in Section 4 (for Benefit and/or Medical Care Determinations), the rights and procedures of a standard internal appeal apply equally to Expedited (Urgent Appeals.

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

SHP will notify the parties involved of its expedited appeal determination orally, or in writing, by facsimile or other expedient means. The Participant and those Practitioners and/or Providers involved in the appeal will also receive written notification within three (3) calendar days of the oral notification.

NOTE: If a Participant's claim or appeal is no longer considered or determined to be urgent or emergent, as defined in this Summary Plan Description, it will be handled according to the Standard (Non-urgent) appeal procedures and timelines, depending upon the circumstances. If the expedited review is a Concurrent Review determination, the service will be continued without liability to the Participant until the Participant or the representative has been notified of the determination.

Expedited (Urgent) Appeal Notification Timelines

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

If the information is not received in a timely manner as stated in Section 4, "*Utilization Management Review Process*", notification will occur as expeditiously as the Participant's medical condition requires, but no later than forty-eight (48) hours after receipt of all the information necessary to process the request forbenefits.

External Independent Review of Final Adverse Determination (Denial)

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

NOTE: Adverse Benefit Determinations, e.g. denials that do not involve medical/clinical review, are not eligible for an External Review. The Plan's decision on Benefit Determinations is final and binding.

External Appeal Review Program Procedures

Conduct of the external review program is as follows:

a. Within five (5) business days following the date of receipt of the external review request, SHP shall complete a preliminary review of the request to determine whether:
   i. The Participant is, or was, a covered person in the Plan 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;
   ii. The health care service that is the subject of the Adverse Determination is a covered service under the Plan but SHP determined 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;
   iii. The Participant has exhausted SHP's internal appeal process, unless the Participant is not required to exhaust SHP's internal appeal process as outlined above; and
   iv. The Participant has provided all the information and forms required to proceed with an external review.
b. Within one (1) business day after completion of the preliminary review, SHP shall notify the Participant and, if applicable, the Participant's authorized representative, in writing whether the request is complete and eligible for external review.
   i. If the request is not complete, SHP shall inform the Participant and, if applicable, the Participant's Authorized Representative, in writing, and include in the notice what information or materials are needed to make the request complete; or
   ii. If the request is not eligible for external review, SHP shall inform the Participant and, if applicable, the Participant's Authorized Representative, in writing, and includes the reasons for its ineligibility.
   iii. If the Independent Review Organization upheld the denial, there is no further review available under this appeals process. However, the Participant may have other remedies available under federal law, such as filing a lawsuit.
c. If the request is complete, within one (1) business day after verifying eligibility, the Plan shall assign an independent review organization and notify in writing the Participant, and, if applicable, the Participant's authorized representative of the request's eligibility and acceptance for external review.
   i. Within ten (10) business days following the date of receipt of the notice provided by SHP, the Participant may submit, in writing, to the assigned Independent Review Organization, any additional information that the independent review organization shall consider when conducting the external eview.
   ii. The independent review organization is not required to, but may, accept and consider additional information submitted after ten (10) business days.
d. Within five (5) business days after the date SHP determines the request is eligible for external review, SHP shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.

e. SHP contracts with the independent, external review organization that:
   i. is accredited by a nationally recognized private accrediting entity;
   ii. conducts a thorough review in which it considers all previously determined facts; allows the introduction of new information; considers and assesses sound medical evidence; and makes a decision that is not bound by the decisions or conclusions of SHP, or determinations made in any prior Grievance or appeal.
   iii. completes their review and issues a written final decision for non-urgent appeals within forty-five (45) calendar days of the request.
   iv. has no material professional, familial or financial conflict of interest with SHP.

f. For clinically Urgent Care appeals, the review and decision will be made and orally communicated as expeditiously as the Participant'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 Participant, or if applicable, the Participant's authorized representative, and their treating Practitioner and/or Provider.

g. With the exception of exercising its rights as party to the appeal, SHP will not attempt to interfere with the Independent Review Organization's proceeding or appeal decision.

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

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

j. The Participant 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 Participant, unless the appeal is of an urgent nature and qualifies as an Expedited (Urgent) External Review Request.

k. The Independent Review Organization's decision is final and binding to the Plan and SHP implements the Independent Review Organization's decision within the timeframe specified by the Independent Review Organization. The decision is not binding to the Participant, because the Participant has legal rights to pursue further appeals in court if they are dissatisfied with the outcome. However, a Participant may not file a subsequent request for external review involving the same adverse determination for which the Participant has already received an external review decision.

SHP obtains from the Independent Review Organization, or 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. SHP 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.

Standard (Non-Urgent) External Review Request

With the Participant's permission, SHP may refer an appeal directly to an external independent review organization without conducting an internal review.

For independent, external review of a final Adverse Determination, SHP will provide:

1. Participants the right to an independent, third party, binding review whenever they meet the following eligibility criteria:
   a. the Participant is appealing an Adverse Determination that is based on medical necessity (Benefit Denials are not eligible);
   b. the Participant has not appealed to the Federal Department of Labor;
   c. SHP has either completed its internal appeal review and its decision is unfavorable to the Participant; or SHP has exceeded the time allowed for making a decision; or SHP, with the Participant's permission, has elected to bypass the available internal level of Appeal; and
   d. the request for independent, external review is filed within *four (4) months* of the date that SHP's Adverse Determination was made.

2. Notification to Participants about the independent, external appeal program and decision are as follows:
   a. General communications to Participants, at the same time SHP sends written notice of an Adverse Determination to announce the availability of the right to independent, external review.
   b. Letters informing Participants and Practitioners and/or Providers 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 Participant does not bear any costs of the independent, external review organization.
   c. The external review organization will communicate its decision in clear terms in writing to the Participant and the Plan. The decision will include:
      i. a general description of the reason for the request for external review, including information sufficient to identify the claim; this information includes the date(s) of service, the provider, claim amount (if applicable), diagnosis and treatment codes (and their corresponding meanings), and the reason for the prior denial;
      ii. the date the independent review organization received the assignment from SHP to conduct the external review;
      iii. the date the external review was conducted;
      iv. the date of its decision;

v. the principal reason(s) for its decision, including any, medical necessity rationale or evidence-based standards that were a basis for its decision;
vi. the list of titles and qualifications, including specialty, of individuals participating in the appeal review; and
vii. a statement of the reviewer's understanding of the pertinent facts of the appeal and reference to evidence or documentation used as a basis for the decision.

d. The external review organization will also notify the Participant how and when Participants receive any payment or service in the case of overturned Adverse Determinations.

Expedited (Urgent) External Review Request Processes & Procedures

1. A Participant or the Participant'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 Participant; or would jeopardize the Participant's ability to regain maximum function; or
   b. in the case of a request for Experimental or Investigational services, the treating Practitioner and/or Provider certifies, in writing, that the requested health care services or treatment would be significantly less effective if not promptly initiated.
2. An expedited external review is not provided for Retrospective Adverse Determinations.
3. Immediately upon receipt of the request from the Participant or the Participant's Representative, SHP 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, SHP will give oral notification to the Participant or the Participant's Representative.
4. Upon determination that the Expedited External Review request meets the reviewability requirements, SHP 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 SHP's utilization review or internal Appeal process.
5. SHP will send all necessary documents and information considered in making the Adverse Determination to the assigned independent review organization electronically, by telephone, or facsimile or any other available expeditious method.
6. The independent review organization will make a decision to uphold or reverse the adverse determination and provide oral notification to the Participant, and, if applicable, the Participant's authorized representative, and the treating Practitioners and/or Providers as expeditiously as the Participant'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 Participant 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 Participant, or the Participant's authorized representative, files a request for an internal Expedited Review of an Appeal involving an Adverse Determination, the Participant, or the Participant's authorized representative, may also file a request for an external Expedited External Review if the Participant has a medical condition where the timeframe for completion of an expedited review would seriously jeopardize the life or health of the Participant or would jeopardize their ability to regain maximum function; or if the requested health care service or treatment is Experimental or Investigational and the Participant'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 the Plan's receipt of the independent review organization's decision to reverse the adverse determination, SHP shall immediately approve the coverage that was the subject of the adverse determination.

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 SHP. Additionally, an overview of your Complaint and Appeal Rights, along with an *Appeal Filing Form*, is included in all Explanation of Benefits (EOBs) generated by SHP.

Section 11. Definitions of Terms in this Summary Plan Description

Term	Definition
Admission	Entry into a facility as an Inpatient for treatment and care when ordered by a Health Care Provider with admitting privileges. An Admission ends when a Participant is discharged or released from the facility and is no longer registered as a patient. Also known as Hospitalization.
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 that is 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 an exclusion, including a 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. Does not include a refusal based on nonpayment by a Provider/Practitioner/Pharmacy to provide services.
Allowance or Allowed Charge	The maximum dollar amount that payment for a procedure or service is based on as determined by SHP.
Ambulatory Surgical Center	A lawfully operated, public or private establishment that: a. Has an organized staff of Practitioners; b. Has permanent facilities that are equipped and operated mostly for performing surgery; c. Has continuous Practitioner services and Nursing Services when a patient is in the Facility; and d. Does not have services for an overnight stay.
Amendment	A formal document that changes the provisions of the Plan Document/Summary Plan Description, duly signed by the authorized person or persons as designated by the Plan Sponsor.
Appeal	A request to change a previous Adverse Determination made by SHP.
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: 1. A federally funded or approved trial; 2. A clinical trial conducted under an FDA investigational new medication application; or 3. A medication trial that is exempt from the requirement of an FDA investigational new medication application.
Authorized Representative	A person to whom a covered person has given express written consent to represent the Participant, a person authorized by law to provide substituted consent for a Participant, a family member of the Participant or the Participant's treating health care professional if the Participant is unable to provide consent, or a health care professional if the Participant's Plan requires that a request for a benefit under the plan be initiated by the health care professional. For any Urgent Care Request, the term includes a health care professional with knowledge of the Participant's medical condition.
Avoidable Hospital Conditions	Conditions that could reasonably have been prevented through application of evidence-based guidelines. These conditions are not present on admission, but present during the course of the stay. Participating Providers are not permitted to bill the Plan or Participants for services related to Avoidable Hospital Conditions.
Beneficiary	Any person designated by a Participant (or by the terms of the Plan under ERISA) who is, or may become, entitled to a benefit under the Plan.
Benefit Period	A specified period of time when benefits are available for Covered Services under this Benefit Plan. A Claim for Benefits will be considered for payment only if the date of service or supply was within the Benefit Period. All benefits are determined on a Calendar Year (January 1st through December 31st) Benefit Period. Also known as Benefit Year.
Benefit Plan	The agreement with SHP, including the Participant's enrollment form, Identification Card, the Benefit Plan Agreement, this Summary Plan Description, the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments
Benefit Year	Aperiod of one year commencing on the effective date (or renewal date) and ending at 11:59 pm on the last day of the benefit year.
Calendar Year	Aperiod of one year, which starts on January 1st and ends December 31st. Aperiod of one year which starts on January 1st and ends December 31st. Calendar Year is also the Benefit Year and/or Benefit Period.

Term	Definition
Case Management	A coordinated set of activities conducted for individual patient management of chronic, serious, complicated, protracted, or other health conditions.
Claim for Benefits	Any request for a plan benefit or benefits made by a claimant in accordance with SHP's reasonable procedure for filing benefit claims. Does not include an inquiry as to eligibility, which does not request benefits.
Claims Administrator	SHP
COBRA	The **C**onsolidated **O**mnibus **B**udget **R**econciliation **A**ct of 1985 and amends to thereafter. COBRA provides for Medical Coverage Continuation for Employees or Dependents who have terminated, divorced or died (see *Options After Coverage Ends* in Section 9 for complete details)
Coinsurance Amount	The percentage of charges to be paid by a Participant 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.
Contract Year	A period of one year commencing on the effective date (or renewal date) and ending at 12:00 midnight on the last day of the one year period.
Copayment [Copay]	A specified dollar amount payable by the Participant for certain Covered Services. Health Care Providers may request payment of the Copayment Amount at the time of service.
Cost Sharing	The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes coinsurance, copayments, or similar charges, but it does not include premiums, balance-billing amounts for non-network providers, or the cost of Non-Covered services.
Covered Services	Those Health Care Services to which a Participant is entitled under the terms of this Plan.
Creditable Coverage	Benefits or coverage provided under: 1. A group health benefit plan; 2. A health benefit plan; 3. Medicare or Medicaid; 4. A health plan offered under 5 U.S.C. 89; 5. A medical care program of the Indian Health Service or of a tribal organization; 6. A state health benefits risk pool; 7. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government; 8. A health benefit plan under §5(e) of the Peace Corps Act Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e); 9. A state's children's health insurance program funded through Title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].
Custodial Care	Care designed to assist the patient in meeting the activities of daily living and not primarily provided for its therapeutic value in the treatment of an illness, disease, injury or condition.
Deductible	The amount that a Participant must pay each Calendar Year before the Plan begins to pay the costs or provide benefits for Covered Services. The following amounts will not apply towards the deductible: 1. Copayments; 2. Amounts for services that are not medically necessary; 3. Amounts for Non-Covered Services as defined by this SPD; 4. Any difference between the covered charges and the Maximum Allowed Amount if you receive services from a Non-Participating and/or Out-of-Network Provider; and 5. Amounts for services that are not properly Prior Authorized. Out-of-Network charges incurred by a Participant. **There is no coverage Out-of-Network unless it is an emergency or urgent care situation.**
Dependent	The Spouse and any Dependent Child of a Participant.

Term	Definition
Dependent Child	A child of the Participant or the Participant's Covered Spouse, who is a biological child; a child placed for adoption; a legally adopted child; a child for whom the Participant, or the Participant's Covered Spouse, has legal guardianship; a stepchild; or a foster child of a Participant or Participant's Covered Spouse; and meets one of the following requirements: 1. under age twenty-six (26); or 2. incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Participant for support and maintenance. If the Plan so requests, the Participant must provide proof of the child's disability within *thirty (30)* days of the Plan's request.
Domiciliary Care	Domiciliary Care consists of a protected situation in a community or Facility, which includes room, board, and personal services for individuals who cannot live independently yet do not require a 24-hour Facility or nursing care.
Eligible Dependent	Any "Dependent" who meets the specific eligibility requirements of the Plan as listed in this Summary Plan Description and under applicable federal laws and rules.
Eligible Employee	Any Employee who meets the specific eligibility requirements of the Plan Sponsor.
Emergency Care Services	Means either: 1. Within the Service Area: covered Health Care Services rendered by Participating or Non-participating Providers under unforeseen conditions that require immediate medical attention, including covered Health Care Services from Non-participating and/or Out-of-Network Providers only when delay in receiving care from In-Network Participating Providers could reasonably be expected to cause severe jeopardy to the Participant's condition; or **2.** Outside the Service Area: Medically Necessary Health Care Services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of SHP's Service Area. **There is no coverage for non-Emergency or non-Urgent are received Out-of-Network.**
Emergency Medical Condition	Sudden and unexpected onset of a health condition that, based on a Prudent Layperson's judgment, 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.
Employee	A person directly involved in the regular business of, and compensated for, services by the Plan Sponsor. 'Employee'includes full-time Employees (those who average 30 or more hours per week).
Employer	The Employer, who has allowed its Eligible Employees, their Eligible Dependents, and any other person or party pursuant to the Employer's eligibility policy, to participate in the Plan by acting as the Plan Sponsor.
Enrollee	An individual who is covered by this Plan. An Enrollee is also a Participant.
ERISA	The Employee Retirement Income Security Act of 1974, or any provision or section thereof, as amended from time to time.
ESRD	The federal End Stage Renal Disease program.
Expedited Appeal	An expedited review involving Urgent Care Requests for Adverse Determinations of Prospective (Pre-service) or Concurrent Reviews will be utilized if the Participant, or Practitioner and/or Provider acting on behalf of the Participant, believes that an expedited determination is warranted.
Experimental or Investigational Services	Health Care Services where the Health Care Service in question either: a. 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 b. 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 Facilities, Residential Treatment Facilities, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings.
Formulary	A list of prescription medication products, which are preferred by the Plan for dispensing to Participants when appropriate. This list is subject to periodic review and modifications. Additional medications may be added or removed from the Formulary throughout the year.
Grievance	A written complaint submitted in accordance with SHP's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the Plan relative to the Participant.

Term	Definition
[The] Group or [This] Group	Sanford.
Health Care Services	Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease.
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, Practitioner and/or Provider's offices, private homes, Ambulatory Surgical Centers, residential or transitional living centers, or similar facilities.
Hospitalization	A stay as an inpatient in a Hospital. Each "day" of Hospitalization includes an overnight stay for which a charge is customarily made.
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 SPD, when a Participant seeks services from a Participating Practitioner and/or Provider designated by Sanford Health Plan, in its sole discretion, as part of this SPD's defined network.
In-Network Facility	A Facility (as defined above) considered "In-Network" by the terms of this SPD.
In-Network Pharmacy	A Pharmacy considered "In-Network" by the terms of this SPD.
In-Network Participating Practitioner and/or Provider	A Participating Practitioner and/or Provider that is considered "In-Network" by the terms of this SPD.
Intensive Outpatient Program (IOP)	Provides mental health and/or substance use disorder outpatient treatment services during which a Participant remains in the program a minimum of three (3) continuous hours per day and does not remain in the program overnight. Programs may be available in the evenings or weekends.
Intermediate Care	Care in a licensed/regulated Facility, corporation or association for the accommodation of persons, who, because of incapacitating infirmities, require minimum, but continuous, care; however, such persons are not in need of continuous medical or nursing services. The term also includes facilities for the nonresident care of elderly individuals and others who are able to live independently but who require care during the day.
Late Enrollee	An Eligible Employee or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage. Late Enrollees may not enroll at any time during the year, only during the next scheduled Open Enrollment Period. A Participant is not a Late Enrollee if special enrollment rights apply, as described in Section 2.
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 Participants 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 Participant whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Health Care Provider.
Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for covered services and supplies. Sanford Health Plan's Maximum Allowed amount is the lesser of: (a) the amount charged for a covered service or supply; or (b) inside Sanford Health Plan's service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or (c) outside of Sanford Health Plan's service area, using current publicly available data adjusted for geographical differences where applicable: i. Fees typically reimbursed to providers for same or similar professionals; or ii. Costs for facilities providing the same or similar services, plus a margin factor.

Term	Definition
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 Participant'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 SHP, 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: a. help restore or maintain the Participant's health; or b. prevent deterioration ofthe Participant's condition; or c. prevent the reasonably likely onset of a health problem or detect an incipient problem; or d. not considered Experimental or Investigative
Mental Health and/or Substance Use Disorder Services	Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD), current editions. Also referred to as behavioral health, psychiatric, chemical dependency, substance abuse, and/or addiction services.
Natural Teeth	Teeth, which are whole and without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.
Never Event	Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a problem in the safety and credibility of a health care Facility. Participating Providers are not permitted to bill the Plan or Participants for services related to Never Events.
Non-Covered Services	Those Health Care Services to which a Participant is not entitled and are not part of the benefits paid under the terms of this Plan.
Non-Participating Practitioner and/or 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.
Non-Payable Health Care Provider	A Health Care Provider that is not reimbursable by SHP. No benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of a Non-Payable Health Care Provider.
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 Participant's immediate family.
Open Enrollment	A period of time at least once a year when Eligible Employees may enroll themselves and their Dependents in the Plan. Annual Enrollment does not pertain to non-Medicare retirees.
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 SPD. .
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 SPD.
Out-of-Pocket Maximum Amount	The total of the Participant's Deductible and Cost Sharing Amounts for certain Covered Services that are a Participant's responsibility during a Benefit Period. When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Covered Services for the remainder of the Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period.
Partial Hospitalization	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.
Participant	Any employee or former employee who is eligible (or may become eligible) to receive any benefit under this Plan, or whose beneficiaries may be eligible to receive any such benefit. Former employees, like retirees or COBRA qualified beneficiaries, are Participants if they are entitled to benefits under this Plan.
Participating Practitioner and/or Provider	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 Participants with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, directly or indirectly, from Sanford Health Plan.
Physician	An individual licensed to practice medicine or osteopathy.

Term	Definition
Plan Administrator	The person or entity named by your Plan Sponsor to manage the Plan and answer questions about Plan details.
[The] Plan Sponsor	The self-funded health and welfare benefit plan under which coverage is provided to Participants by the Plan Sponsor (employer group).
Practitioner	A professional who provides health care services. Practitioners are usually required to be licensed as required by law. Practitioners are also Physicians.
Preauthorization [or Certification]	The process of the Participant or the Participant's representative notifying SHP to request approval for specified services. Eligibility for benefits for services requiring Preauthorization is contingent upon compliance with the provisions in Section 3 and 4. Preauthorization does not guarantee payment of benefits. Also known as "Certification."
Premium	The amount paid by the Participant to the Plan Sponsor on a monthly basis for the Plan to provide coverage for Participants under this Plan. Premium is also the amount paid by the Plan Sponsor to cover Plan expenses and claims for coverage for Participants under this Plan.
Pre-service claim	Must involve mandatory preauthorization/certification. Does not include a request for pre-approval of a benefit under this Plan when such benefit does not require preauthorization/certification.
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 SHP.
Primary Care Practitioner and/or Provider (PCP)	A Participating Practitioner and/or 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 Practitioner and/or Provider as indicated in the Provider Directory and may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Participant.
Prospective (Pre-service) Review	Means Urgent and non-Urgent Utilization Review conducted prior to an admission or the provision of services, including courses of treatment.
[Health Care] Provider	An individual, institution or organization that provides services for Plan Participants. Examples of Providers include but are not limited to Hospitals, Physicians, Practitioners and/or Providers, and home health agencies.
Prudent Layperson	A person who is without medical training and who possess an average knowledge of health and medicine and who draws on his/her practical experience when making a decision regarding the need to seek Emergency medical treatment.
Qualified Mental Health Professional	A licensed Physician who is a psychiatrist; a licensed clinical psychologist who is qualified for listing on the national register of health service providers in psychology; a licensed certified social worker who is a board-certified in clinical social work; or a nurse who holds advanced licensure in psychiatric nursing
Rescission	A cancellation or discontinuance of coverage, including any benefits paid, that has a retroactive effect of voiding coverage under this Plan, or any benefits paid under the terms of this Plan.
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 SHP to review services that have already been utilized.

Term	Definition
Serious Reportable Event	An event that results in a physical or mental impairment that substantially limits one or more major life activities of a Participant or a loss of bodily function, if the impairment or loss lasts more than seven (7) days or is still present at the time of discharge from an inpatient health care Facility. Serious events also include loss of a body part and death. Participating Providers are not permitted to bill Participants or the Plan for services related to Serious Reportable Events.
Service Agreement	The contract between the Plan Sponsor and SHP to provide administrative services, process claims, and perform preauthorization and/or utilization review processes for Participants under this Plan.
SHP	The geographic Service Area as defined by Sanford Health Plan in the Introduction of this SPD.
Service Area	The geographic Service Area as defined by SHP in the Introduction of this Summary Plan Description.
Skilled Nursing Facility	A Facility that is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly licensed Physician, and such facility is licensed in the state in which it operates.
Spouse	An individual who is legally married to a Participant. The term "Spouse" does not include individuals in common-law marriages or those individuals in domestic partnerships. The sexual orientation, sex, gender, and/or gender identity of Spouses is not a factor in benefit or eligibility determinations.
Summary Plan Description (SPD)	A document describing the essential features, services, and limitations for coverage available to the Participant under this Plan.
TRICARE [or CHAMPUS]	A U.S. Military program that provides coverage for health care services.
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 which: 1. Could seriously jeopardize the life or health of the Participant or the ability of the Participant 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 Participant's medical condition, would subject the Participant to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
Urgent Care Situation	An Urgent Care Situation is a degree of illness or injury, 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.
Utilization Review	A set of formal techniques used by SHP to monitor and evaluate the medical necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Prospective (pre-service) Review, second opinion, Certification, Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review.
You/Your	The Participant as shown by context.

Appendix A

Participating Employers

Sanford Health
2301 E. 60th St. N.
Sioux Falls, SD 57117
EIN: 31-1527032

Sanford Medical Center
1305 W.18th St.
Sioux Falls, SD 57105
EIN: 46-0227855

Sanford Clinic
1305 W.18th St.
Sioux Falls, SD 57105
EIN: 46-0447693

Sanford Health Network
1305 W.18th St.
Sioux Falls, SD 57105
EIN: 46-0388596

Sanford Health Foundation
1305 W.18th St.
Sioux Falls, SD 57105
EIN: 36-3297853

Sanford North
736 N. Broadway
Fargo, ND 58122
EIN: 45-0385890

Sanford Medical Center Fargo
801 N. Broadway
Fargo, ND 58122
EIN: 45-0226909

Edith Sanford Breast Center Foundation
1305 W. 18th St.
Sioux Falls, SD 57105
EIN: 45-0404126

Sanford Health Network North
736 N. Broadway
Fargo, ND 58122
EIN: 45-0409348

Sanford Health Plan
300 Cherapa Place, #201
Sioux Falls, SD 57103
EIN: 91-1842494

Sanford Home Medical Equipment, Inc.
1305 W.18th St.
Sioux Falls, SD 57105
EIN: 46-0388597

Sanford Home Health
1305 W.18th St.
Sioux Falls, SD 57105
EIN: 46-0282134

Sanford Frontiers
300 Cherapa Place
Sioux Falls, SD 57103
EIN: 45-5436599

Sanford World Clinics
2301 E. 60th St. N.
Sioux Falls, SD 57117
EIN: 26-2707628

Sanford Clinic North
801 N. Broadway
Fargo, ND 58102
EIN: 91-1770748

Sanford HealthCare Accessories, L.L.C.
3223 32nd Avenue S.
Fargo, ND 58103
EIN: 02-2404179

Sanford Health Foundation North
717 4th St. N.
Fargo, ND 58122
EIN: 45-0398104

Sanford Medical Center Thief River Falls
120 LaBree Avenue S.
Thief River Falls, MN 56701
EIN: 41-0709579

Sanford Medical Center Wheaton
401 12th St. N.
Wheaton, MN 56296
EIN: 27-2042143

Sanford Health Foundation West
300 N. 7th St.
Bismarck, ND 58501
EIN: 45-0397196

Sanford Affiliated Services
300 N. 7th St.
Bismarck, ND 58501
EIN: 45-0403146

Sanford Living Centers
1000 18th St. N.W.
Mandan, ND 58554
EIN: 45-0416454

Sanford Medical Center Mayville
42 6th Avenue S.E.
Mayville, ND 58257
EIN: 45-0228899

HealthCare Environmental Services LLC
1420 40th St. N.
Fargo, ND 58103
EIN: 20-5236701

Sanford Health of Northern Minnesota
1300 Anne St. N.W.
Bemidji, MN 56601
EIN: 41-1266009

Sanford Hillsboro
12 3rd St. S.E.
Hillsboro, ND 58045
EIN: 45-0230400

Sanford Hillsboro Foundation
12 3rd St. S.E.
Hillsboro, ND 58045
EIN: 36-3542187

Sanford West
300 N. 7th St.
Bismarck, ND 58501
EIN: 45-0397195

Sanford Bismarck
300 N. 7th St.
Bismarck, ND 58501
EIN: 45-0226700

F-M Ambulance Service, Inc.
2215 18th St. S.
Fargo, ND 58103
EIN: 45-0344371

Sanford
801 Broadway North
Fargo, ND 58102
EIN: 27-1218956