North Dakota Public Employees Retirement System (NDPERS)

2025-2027 Certificate of Insurance

Dakota Plan

Grandfathered PPO/Basic

Help understanding this document is free.

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Please call (800) 752-5863 *(toll-free)* | TTY/TDD: 711*(toll-free)* to connect with us using free translation services.

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM | SANFORD HEALTH PLAN

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FREE HELP IN OTHER LANGUAGES

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

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

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

Arabic

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Notice

Your employer has established an employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Summary Plan Description/Certificate of Insurance (COI) is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA). Every attempt has been made to provide concise and accurate information.

This COI and the NDPERS Service Agreement are the official benefit plan documents for the employee welfare benefit plan established by the Plan Administrator. In case of conflict between this Certificate of Insurance/Summary Plan Description and the NDPERS Service Agreement, the provisions of the NDPERS Service Agreement will control.

Although it is the intention of the Plan Administrator to continue the employee welfare benefit plan for an indefinite period of time, the Plan Administrator reserves the right, whether in an individual case or in general, to eliminate the Benefit Plan.

Sanford Health Plan shall construe and interpret the provisions of the Service Agreement, the COI and related documents, including doubtful or disputed terms; and to conduct any and all reviews of claims denied in whole or in part. NDPERS shall determine all questions of eligibility.

Plan Name

North Dakota Public Employees Retirement System Dakota Plan

Name and Address of Employer (Plan Sponsor)

North Dakota Public Employees Retirement System
1600 E. Century Avenue, Suite 2
PO Box 1657
Bismarck, ND 58503

Plan Sponsor's IRS Employer Identification Number

45-0282090

Plan Number Assigned By the Plan Sponsor

N/A

Type of Welfare Plan

Health

Type of Administration

This employee welfare benefit plan is fully insured by Sanford Health Plan and issued by Sanford Health Plan. Sanford Health Plan is the Claims Administrator for this employee welfare benefit plan.

Name and Address of Sanford Health Plan

Sanford Health Plan
4800 W 57th St.
Sioux Falls, SD 57108
(877) 305-5463 *(toll-free)*
TTY/TDD: 711 *(toll-free)*

Plan Administrator's Name, Business Address and Business Telephone Number

North Dakota Public Employees Retirement System
1600 E. Century Avenue, Suite 2
PO Box 1657
Bismarck, ND 58503
(701) 328-3900

Name and Address of Agent for Service of Legal Process

Plan Administrator	Sanford Health Plan
North Dakota Public Employees Retirement System Executive Director 1600 E. Century Avenue, Suite 2 PO Box 1657 Bismarck, ND 58503	Sanford Health Plan ATTN: President 4800 W 57th St. PO Box 91110 Sioux Falls, SD 57109-1110

Title of Employees Authorized To Receive Protected Health Information

- Administrative Services Division
- Accounting & IT Division
- Benefit Programs Division
- Benefit Program Development & Research
- Executive Director
- Internal Audit Division

This includes every employee, class of employees, or other workforce person under control of the Plan Sponsor who may receive the Member'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.

These identified individuals will have access to the Member's Protected Health Information only to perform the plan administrative functions the Plan Sponsor provides to the Benefit Plan. Such individuals will be subject to disciplinary action for any use or disclosure of the Member's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Plan Sponsor 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 Member whose privacy may have been compromised.

Statement of Eligibility to Receive Benefits
As provided in N.D.C.C. §54-52.1-01(4), individuals eligible to receive benefits are every permanent employee who is employed by a governmental unit, as that term is defined in N.D.C.C. §54-52-01, whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1,2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. An eligible employee includes members of the Legislative Assembly, judges of the Supreme Court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by N.D.C.C. §54-06-01(2), and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund.

A temporary employee employed before August 1, 2007, may elect to participate in the uniform group insurance program by completing the necessary enrollment forms and qualifying under the medical underwriting requirements of the program if such election is made before January 1, 2015, and if the temporary employee is participating in the uniform group insurance program on January 1, 2015. In order for a temporary employee employed after July 31, 2007, to qualify to participate in the uniform group insurance program, the employee must be employed at least twenty hours per week; must be employed at least twenty weeks each year of employment; must make the election to participate before January 1, 2015; and must be participating in the uniform group insurance program as of January 1, 2015. To be eligible to participate in the uniform group insurance program, a temporary employee first employed after December 31, 2014, or any temporary employee not participating in the uniform group insurance program as of January 1, 2015, must meet the definition of a full-time employee under §4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)].

An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment or eligibility for a special enrollment period as set forth in N.D.A.C. §71-03-03. Each eligible employee may elect to enroll his/her Eligible Dependents.

Eligible employees also include non-Medicare eligible retired and terminated employees, and their Eligible Dependents, who remain eligible to participate in the uniform group insurance program pursuant to applicable state law, as provided in N.D.C.C. §54-52.1-03 and federal regulations. Eligible employees may also include Medicare eligible retirees who enrolled in the Dakota Retiree Plan and lost eligibility to participate in the Dakota Retiree Plan due to the loss of Medicare Part B. For a comprehensive description of eligibility, refer to the NDPERS web site at www.ndpers.nd.gov.

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan Administrator. When an eligible employee meets the criteria for eligibility, a membership application must be completed. NDPERS has the ultimate decision making authority regarding eligibility to receive benefits.

Description of Benefits

See the Schedule of Benefits and the Covered Services Sections. Refer to the Table of Contents for page numbers.

Sources of Premium Contributions to the Plan and the Method by Which the Amount of Contribution Is Calculated

The contributions for single or family for state employees are paid at 100% by the State. The contributions for employees of participating political subdivisions are at the discretion of the subdivision and subject to the minimum contribution requirements and participation requirements of Sanford Health Plan. Either the contributions for temporary employees are at their own expense or their employer may pay the premium subject to its budget authority.

End of the Year Date for Purposes of Maintaining the Plan's Fiscal Records

June 30

Clerical Error

Any clerical error by either the Plan or Claims Administrators, or the aforementioned entities' designees, 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, Sanford Health Plan and NDPERS retain contractual rights to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money.

Recovery of Benefit Payments
Pursuant to N.D.A.C. §71-03-05-06, whenever benefits are paid in noncompliance with the Contract, NDPERS, which is the Plan Administrator, or an agent of the Plan Administrator, retains the right to recover the payments from the party responsible.

If Sanford Health Plan, which is the Claims Administrator and Payor, or an agent of Sanford Health Plan, is at fault, the amount of overpayment will be withheld from the administrative fees paid by NDPERS.

If overpayments are made because of false or misleading information provided by a Member, Sanford Health Plan, or an agent of Sanford Health Plan, shall attempt to recover the amount. Any moneys recovered shall be credited to NDPERS.

If an overpayment is made because of a mistake or deliberate act by a Health Care Provider, Sanford Health Plan shall collect the money from the Provider and credit that amount to NDPERS.

If fraud is suspected, Sanford Health Plan shall inform NDPERS and NDPERS may turn the evidence over to the North Dakota State's Attorney or Attorney General's office for possible prosecution.

Amending and Terminating this Benefit Plan
As Plan Administrator, NDPERS has delegated responsibility for determinations regarding covered benefits, and the amount and manner of the payment of benefits, including the appeal of denied claims, to Sanford Health Plan, the insurer of the plan.

NDPERS reserves the right to terminate the plan, or amend or eliminate benefits under the North Dakota Public Employees Retirement System Dakota Plan, as insured and issued by Sanford Health Plan, at any time and at its discretion, upon mutual agreement between NDPERS and Sanford Health Plan. Should this Benefit Plan be amended or terminated, such action shall be by a written instrument duly adopted by both NDPERS and Sanford Health Plan, or the aforementioned entities' designees

Fiduciary Duties

Claims Administrator Is a Fiduciary

Except for direct member appeals regarding an infertility services deductible, the North Dakota Public Employees Retirement Board has delegated to the Claims Administrator, herein known as Sanford Health Plan, benefit claims and appeals. Sanford Health Plan is a Plan fiduciary for these benefit claims and appeals only. As such, the Claims Administrator has the final and discretionary authority to determine these 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 the Claims Administrator on review is final and binding, subject to your right to file a lawsuit under other applicable laws. This decision making authority is limited only by the duties imposed. Any determination by the Claims Administrator is intended to be given deference by courts to the maximum extent allowed under applicable

laws.

Summary Notice and Important Phone Numbers

This COI describes in detail your Employer's health care benefit Plan and governs the Plan's coverage. This COI, any amendments, and related documents comprise the entire Plan between the Employer and the Claims Administrator.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this COI carefully. If you have any questions about the benefits, please contact Sanford Health Plan's Customer Service. For contact information, See "Introduction; How to Contact Sanford Health Plan [The "Plan"].

This COI describes in detail the Covered Services provisions and other terms and conditions of the Plan.

NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices ("Notice") applies to Sanford Health Plan including Align powered by Sanford Health Plan and Great Plains Medicare Advantage. If you have questions about this Notice, please contact Customer Service at (800) 752-5863 *(toll-free)* | TTY/TDD 711.
This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by Sanford Health Plan, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a Member under a policy or contract, or a prospective Member, obtained by Sanford Health Plan from that person or from a health care Provider, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form, is confidential and may not be disclosed to any person except as set forth below.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

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

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

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

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

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

- **When required by law**: We will share information about you if State or federal law require it, including with the Department of Health and Human services if it wants to see that we're complying with federal privacy law.
- **For public health and safety**: We can share information in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone's health or safety.
- **Organ and tissue donation**: We can share information about you with organ procurement

organizations.

- **Medical examiner or funeral director**: We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers' compensation and other government requests**: We can share information to employers for workers' compensation claims. Information may also be shared with health oversight agencies when authorized by law, and other special government functions such as military, national security and presidential protective services.
- **Law enforcement**: We may share information for law enforcement purposes. This includes sharing information to help locate a suspect, fugitive, missing person or witness.
- **Lawsuits and legal actions**: We may share information about you in response to a court or administrative order, or in response to a subpoena.
- **Research**: We can use or share your information for certain research projects that have been evaluated and approved through a process that considers a Member's need for privacy.

We may contact you in the following situations:

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

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION

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

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

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

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

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

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

CHANGES TO THIS NOTICE

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

EFFECTIVE DATE

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

INTRODUCTION

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

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

How to contact Customer Service

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

Method	Customer Service Contact Information
CALL	(800) 499-3416 *calls to this number are free*
TTY	711
FAX	(605) 328-6812
HOURS	7:30 a.m. to 5:00 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com
WRITE	Sanford Health Plan Customer Service PO Box 91110 Sioux Falls, SD 57109-1110

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

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

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

How to contact Pharmacy Management

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

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

How to contact Appeals and Grievances

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

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

How do I request an external review

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

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

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

MEMBER RIGHTS

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

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

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

MEMBER RESPONSIBILITIES

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

- Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible Provider. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
- Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when telephoning or contacting the Plan.
- Members are responsible for following all access and availability procedures.
- Members are responsible for seeking emergency care at a Plan participating Emergency Facility whenever possible. In the event an ambulance is used, direct the ambulance to the nearest participating emergency Facility unless the condition is so severe that the Member must use the nearest emergency Facility. State law requires that the ambulance transport you to the Hospital of your choice unless that transport puts you at serious risk.
- Members are responsible for notifying Sanford Health Plan of an emergency admission no later than forty-eight (48) hours after becoming physically or mentally able to give notice or as soon as reasonably possible.
- Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible Practitioner or the Hospital.
- Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health conditions, including mental health and/or substance use disorders.
- Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
- Members are responsible for notifying NDPERS within *thirty-one (31)* days of name, address, or telephone number changes.
- Members are responsible for notifying NDPERS of any changes of eligibility that may affect their membership or access to services. The Plan Sponsor is responsible for notifying the Plan.

DISCLOSURE OF GRANDFATHERED STATUS

This employer group health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits; and requirements under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status can be directed to Sanford Health Plan at memberservices@sanfordhealth.org. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or dol.gov/ebsa/healthreform. The Department of Labor website has a table summarizing which protections do and do not apply to grandfathered health plans.

SERVICE AREA

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

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

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

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

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

MEDICAL TERMINOLOGY

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

DEFINITIONS

Capitalized terms are defined in Section 11 of this Policy.

CONFORMITY WITH STATE AND FEDERAL STATUTES

Any provision in this Policy not in conformity with North Dakota laws or rules may not be rendered invalid but must be construed and applied as if it were in full compliance with any applicable State and Federal statutes. If, on the effective date of this policy, any provision of this policy is in conflict with federal statutes, or the statutes

of the State of North Dakota, then this Policy shall be considered amended to conform to the minimum requirements of such laws and regulations.

GOVERNING LAW

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

SPECIAL COMMUNICATION NEEDS

Please call the Plan if you need help understanding written information at (800) 499-3416 *(toll-free)* | TTY/TDD 711 *(toll-free)*. We can read forms to you over the phone and we offer free oral translation in any language through our translation services. Anyone with any disability, who might need some form of accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at (701) 328-3900.

TRANSLATION SERVICES

The Plan can arrange for translation services. Free written materials are available in several different languages and free oral translation services are available. Call toll-free (800) 752-5863 *(toll-free)* | TTY/TDD 711 *(toll-free)* for help and to access translation services.

Spanish (Español): Para obtener asistencia en Español, llame al (800) 752-5863 *(toll-free)*.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 752-5863 *(toll-free)*.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 752-5863 *(toll-free)*.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 752-5863 *(toll-free)*.

SERVICES FOR THE DEAF, HEARING IMPAIRED, and/or VISUALLY IMPAIRED

If you are deaf or hearing impaired and need to speak to the Plan, call TTY/TDD: 711*(toll-free)*. Please contact the Plan toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this COI or other written materials.

In compliance with the Americans with Disabilities Act, this document can be provided in alternate formats. If you require accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at (701) 328-3900.

FRAUD

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

- File accurate claims. If someone else files claims on your behalf, you should review the form before you sign it;
- Review the Explanation of Benefits (EOB) form when it is returned to you. Make certain that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your ID card is lost, you should report the loss to Sanford Health Plan immediately; and

- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

If you are uncertain or concerned about any information or charge that appears on a bill, form, or Explanation of Benefits; or if you know of, or suspect, any illegal activity, call Sanford Health Plan at (800) 499-3416 *(toll-free)* | TTY/TDD 711 *(toll-free)*. All calls are strictly confidential.
In the absence of fraud, all statements made by applicants, the Group or a Member shall be deemed representations and not warranties, and no statements made for the purpose of effecting coverage shall avoid such coverage or reduce benefits unless contained in a written instrument signed by the Group or Member, a copy of which has been furnished to such Group or Member or the Member's representative.

PHYSICAL EXAMINATION

Sanford Health Plan at its own expense may require a physical examination of the Member 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.

CLERICAL ERROR

Any clerical error by either the Plan or Claims Administrators, or the aforementioned entities' designees, 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, Sanford Health Plan and NDPERS retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money.

VALUE-ADDED PROGRAM

Sanford Health Plan may, from time to time, offer health or fitness related programs to our Members through which Members may receive rewards, access discounted rates from certain vendors for products and services available to the general public, or other incentives to engage in a healthy lifestyle or to adopt healthy habits. Products and services available under any such program are not Covered Services. Any such programs are not guaranteed and could be discontinued at any time. Sanford Health Plan does not endorse any vendor, product or service associated with such a program and the vendors are solely responsible for the products and services you receive.

SUMMARY OF THIS PLAN DESCRIPTION

- This Certificate of Insurance serves as your health benefits policy and describes in detail your Employer's health care benefit plan and governs the coverage. The Certificate of Insurance, and any amendments and/or riders, comprise the entire contract between the Employer and Sanford Health Plan.
- A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate of Insurance carefully. If you have any questions about the benefits as presented in the Certificate of Insurance, please contact your Employer or Sanford Health Plan Customer Service.
- This Certificate of Insurance describes in detail the Covered Services provisions and other terms and conditions of the Plan.

NOTICE OF NON-DISCRIMINATION

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

Sanford Health Plan:

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

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

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

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

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

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

SECTION 1.
ENROLLMENT

1.1 ELIGIBILITY AND WHEN TO ENROLL

As provided in N.D.C.C. §54-52.1-01(4), individuals eligible to receive benefits are every permanent employee who is employed by a governmental unit, as that term is defined in N.D.C.C. §54-52-01, whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1,2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. An eligible employee includes members of the Legislative Assembly, judges of the Supreme Court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by N.D.C.C. §54-06-01(2), and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund.

A temporary employee employed before August 1, 2007, may elect to participate in the uniform group insurance program by completing the necessary enrollment forms and qualifying under the medical underwriting requirements of the program if such election is made before January 1, 2015, and if the temporary employee is participating in the uniform group insurance program on January 1, 2015. In order for a temporary employee employed after July 31, 2007, to qualify to participate in the uniform group insurance program, the employee must be employed at least twenty hours per week; must be employed at least twenty weeks each year of employment; must make the election to participate before January 1, 2015; and must be participating in the uniform group insurance program as of January 1, 2015. To be eligible to participate in the uniform group insurance program, a temporary employee first employed after December 31, 2014, or any temporary employee not participating in the uniform group insurance program as of January 1, 2015, must meet the definition of a full-time employee under §4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)].

An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment or eligibility for a special enrollment period as set forth in N.D.A.C. §71-03-03. Each eligible employee may elect to enroll his/her Eligible Dependents.

Eligible employees also include non-Medicare eligible retired and terminated employees, and their Eligible Dependents, who remain eligible to participate in the uniform group insurance program pursuant to applicable state law, as provided in N.D.C.C. §54-52.1-03 and federal regulations. Eligible employees may also include Medicare eligible retirees who enrolled in the Dakota Retiree Plan and lost eligibility to participate in the Dakota Retiree Plan due to the loss of Medicare Part B. For a comprehensive description of eligibility, refer to the NDPERS web site at www.ndpers.nd.gov.

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan Administrator. When an eligible employee meets the criteria for eligibility, a membership application must be completed. NDPERS has the ultimate decision making authority regarding eligibility to receive benefits.

A “Late Entrant” is an Eligible Group Member or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage. A Late Entrant can only enroll during the next

scheduled Open Enrollment Period. A Member is not a "Late Entrant" if "special enrollment rights" apply, as described later in this section.

1.2 HOW TO ENROLL

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

The Eligible Group Member must:

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

The Group must:

- Provide all information needed by Sanford Health Plan to determine eligibility; and
- Agree to pay the required premium payments on behalf of the Eligible Group Member.

1.3 WHEN COVERAGE BEGINS

Coverage generally becomes effective on the first day of the month that follows the date of hire, as designated by NDPERS.

If you are an inpatient in a Hospital or other Facility on the day your coverage begins, we will pay benefits for Covered Services that you receive beginning on the date your coverage becomes effective, as long as you receive Covered Services in accordance with the terms of this Certificate. Payment of benefits is subject to any obligations under a previous plan or coverage arrangement in accordance with state law and applicable regulations.

For more information, see Section 8, "*Extension of Benefits for Total Disability*".

1.4 ELIGIBILITY REQUIREMENTS FOR DEPENDENTS

The following Dependents are eligible for coverage ("Dependent coverage"):
Spouse - The Subscriber's spouse under a legally existing marriage. A Spouse is eligible for coverage, subject to eligibility requirements as designated by NDPERS.

Dependent Child - To be eligible for coverage, a Dependent Child must meet all 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
2) Be one of the following:
   - under twenty-six (26) years old; or
   - incapable of self-sustaining employment by reason of a disabling condition, and chiefly dependent upon the Policyholder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the Dependent Child's disability within *thirty-one (31)* days of the Plan's request. Such a request may be no more than annually following the two year period of the disabled dependent child's attainment of the limiting age [N.D.C.C. §26.1-36-22 (4)]; If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled

dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility.

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

- natural child of a Dependent Child;
- child placed with a Dependent Child for adoption;
- child legally adopted by a Dependent Child;
- child for whom a Dependent Child has legal guardianship;
- stepchild of a Dependent Child; or
- foster child of a Dependent Child.

Limitations. A Dependent shall not be covered under this Contract if he or she is eligible to be a Subscriber, already covered as a Dependent of another Subscriber, or already covered as a Subscriber.

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

1.5 NONCUSTODIAL SUBSCRIBERS

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

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

1.6 STATUS OF MEMBER ELIGIBILITY

The Plan Administrator agrees to furnish Sanford Health Plan with any information required by Sanford Health Plan for the purpose of enrollment. Any changes affecting a Member's eligibility for coverage must be provided to Sanford Health Plan by the Plan Administrator and/or the Member immediately, but in any event, the Plan Administrator and/or the Member shall notify Sanford Health Plan within 31 days of the change.

Statements made on membership applications are deemed representations and not warranties. No statements made on the membership application may be used in any contest unless a copy has been furnished to that person, or in the event of the death or incapacity of that person, to the individual's beneficiary or personal representative. The Subscriber is provided a copy of the membership application at the time of completion.

A Member making a statement (including the omission of information) on the membership application 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 this Benefit Plan by Sanford Health 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.

1.7 WHEN AND HOW TO ENROLL DEPENDENTS

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

How to Enroll Dependents

The Group Member must:

1. Complete the enrollment process, as designated by NDPERS, for the Group Member and any Eligible Dependents; and

2. Provide all information needed to determine the eligibility of the Group Member and/or Dependents, if requested by the Plan.

1.8 WHEN DEPENDENT COVERAGE BEGINS

A. **General**

If a Dependent is enrolled at the same time the Subscriber enrolls for coverage through NDPERS, the Dependent's effective date of coverage will be the same as the Subscriber's effective date as described in Section *"When Coverage Begins"* above.

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

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

C. **Coverage from Birth**

If a Subscriber has a child through birth, the child will become a covered Dependent from the date of birth. Depending on the Class of Coverage the Subscriber is enrolled under, the following provisions apply:

- **a. Subscribers with Single Coverage:** Newborns are covered under a Single Coverage Plan through the date of mother's discharge from the hospital in which the child was born. For coverage to extend after the mother's hospital discharge, Subscribers must submit application to NDPERS within thirty-one (31) days of the newborn's date of birth. Coverage will then be applied retroactively back to the date of birth.
- **b. Subscribers with Family Coverage:** Newborn children will be added to the Certificate automatically if the Subscriber is enrolled in Family Coverage.

A Dependent of Dependent (Subscriber's Grandchild), as defined by the eligibility criteria listed above, must be added to the Subscriber's policy within thirty-one (31) days of birth to qualify for coverage.

An Eligible Group Member who failed to enroll during a previous enrollment period shall be covered under this Contract from the date of the child's birth, provided that coverage is applied for through NDPERS within *thirty-one (31)* days of the birth. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

Dependent coverage is available for the Spouse. The Spouse may be added if application is made within thirty-one (31) days of a child's birth if otherwise eligible for coverage under the Plan, provided that coverage is applied through NDPERS for the Spouse and, if applicable, the Group Member.

D. **Adoption or Children Placed for Adoption**
If a Subscriber adopts a child or has a child placed with him or her as a Dependent, that child will become covered as an Eligible Dependent as of the date specified within a court order or other legal adoption papers. Regardless of the Class of Coverage the Subscriber is enrolled under, the following provisions apply:

a. **Subscribers with either Single or Family Coverage:** For coverage to continue beyond thirty-one (31) days of the date specified within the court order or other legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage, the Subscriber must submit an application for coverage to NDPERS within thirty-one (31) days of the date specified within the court order or other legal adoption papers that granted initial eligibility.

An Eligible Group Member, and any other Dependents, eligible to be enrolled in the Plan, who failed to enroll during a previous enrollment period, shall be covered as of the date specified within a court order or other legal adoption papers, if the Eligible Group Member, and any other Eligible Dependents, submits an application for coverage to NDPERS within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for coverage under the Plan, provided that an application for coverage is submitted to NDPERS for the Spouse and, if applicable, the Group Member, within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage.

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

E. **New Spouses and Dependent Children**
If a Subscriber gets married, his or her Spouse, and any of the Spouse's Dependents who thus become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for with NDPERS for the Spouse and/or Eligible Dependents within thirty-one (31) days of the date of marriage. If the Subscriber does not submit an application for coverage to NDPERS for the Spouse and/or any Eligible Dependent(s) within thirty-one (31) days of the date of marriage, then Late Enrollee provisions apply and the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st. This includes marriages for which coverage was effective on or after June 26, 2015, regardless of the Spouses' gender/sex.

If an Eligible Group Member, who is an Employee eligible to enroll in the Plan, but who did not do so during a previous enrollment period, gets married, the employee becomes an eligible Subscriber under the following conditions:

a. The Subscriber, his or her Spouse, and any Dependents who thus become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for within thirty-one (31) days of the date of marriage or as applicable during the Special Enrollment Period detailed under notation F in the Special Enrollment Rights section.
b. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

** **NOTE:** Per Federal laws, guidance, and regulations, the sexual orientation and sex/gender of Spouses, married in a jurisdiction with legal authority to authorize their marriage, is not a factor in the issuance of coverage or benefit determinations. Sanford Health Plan, in compliance with federal guidance for all states, offers coverage to all legally married Spouses, and any Eligible Dependents as a result of marriage, regardless of the jurisdiction in which the marriage occurred. The provisions in this contract regarding Spousal eligibility and Late Enrollees continue to apply, regardless of Spouses' sex/gender.

1.9 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) PROVISION

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

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

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

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

Exceptions
If a court has ordered a Subscriber to provide health coverage for a Dependent Child, the above requirements under *Dependent Child* need not be satisfied, but the Subscriber must still request enrollment on behalf of the Dependent Child as set forth in this Certificate of Insurance. If the Subscriber fails to enroll the Dependent Child, the other parent may enroll the Dependent Child. A Dependent Child who is provided coverage pursuant to this exception shall not be terminated unless Sanford Health Plan is provided satisfactory written evidence of any of the following:
1. The court or administrative order is no longer in effect;
2. The Dependent Child(ren) currently receive(s) or will be enrolled in comparable health coverage through a health insurance issuer which will take effect not later than the effective date of the termination; or

3. The Group has eliminated family coverage for all of its Eligible Group Members.

1.10 SPECIAL ENROLLMENT PROCEDURES AND RIGHTS

A Special Enrollment Period may apply when an individual becomes an Eligible Dependent through marriage, birth, adoption, or placement for adoption or when an Eligible Group Member or an Eligible Dependent involuntarily loses other health coverage.

A. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any mailing address change within thirty-one (31) days of the change.

B. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any change in marital status within thirty-one (31) days of the change or as applicable during the Special Enrollment Period detailed under notation F in the Special Enrollment Rights section.

1. If the Subscriber marries, Eligible Dependents may be added as a Member if a membership application is submitted within 31 days of the date of marriage. If the membership application is not submitted within the 31-day period, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

   If the membership application is submitted within thirty-one (31) days of the date of marriage, the effective date of coverage for the Eligible Dependent will be the first of the month immediately following the date of marriage. If the membership application is not submitted within thirty-one (31) days of the date of marriage and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

2. If a Member becomes otherwise ineligible for group membership under this Benefit Plan due to legal separation, divorce, annulment, or death, coverage for the Subscriber's Spouse and/or Dependents under Family Coverage will cease, effective the first of the month immediately following timely notice of the event causing ineligibility.

   If living in the Sanford Health Plan Service Area (see *Service Area* in Introduction Section), a Member has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit sanfordhealthplan.com/ndpers or call Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*.

   There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.

C. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) and Sanford Health Plan of any change in family status within thirty-one (31) days of the change. The effective date of coverage for dependents added to this Benefit Plan within the designated time period will be the date of birth, physical placement, or the first of the month immediately following the date established by court order. If a membership application is not submitted within the designated time period and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

   The following provisions will apply:

1. At the time of birth, natural children will automatically be added to the Subscriber's Benefit Plan if Family Coverage is in force. If the Subscriber is enrolled under another Class of Coverage, the Subscriber must submit a membership application for the newborn child within thirty-one (31) days of the date of birth for

coverage to continue beyond the first thirty (30) days beginning with the child's birth. If the membership application is not submitted within the designated time period and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

2. Adopted children may be added to this Benefit Plan if a membership application, accompanied by a copy of the placement agreement or court order, is submitted to NDPERS within thirty-one (31) days of physical placement of the child. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
3. Children who have been placed under the care Subscriber, or the Subscriber's living, covered spouse due to the Subscriber, or the Subscriber's living, covered spouse being appointed legal guardian, may be added to this Benefit Plan by submitting a membership application within thirty-one (31) days of the date legal guardianship is established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits may be added to this Benefit Plan by submitting a membership application within thirty-one (31) days of the date established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
5. If any of the Subscriber's children, or those of the Subscriber's living, covered spouse, who are Eligible Dependents under the Plan, beyond the age of 26, incapable of self-sustaining employment by reason of a disabling condition, and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance, shall have coverage remain in effect as long as such disabled child remains dependent upon the Certificate holder/Subscriber or the Subscriber's spouse for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within *thirty-one (31)* days of the Plan's request.
6. If a child is no longer an Eligible Dependent under this Benefit Plan, and the child is living in the Sanford Health Plan Service Area (see *Service Area* in the above Introduction Section), the Dependent has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit sanfordhealthplan.com/ndpers or call Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*. There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.
7. At the time of birth or adoption, other Eligible Dependents may be added to this Benefit Plan if a membership application is submitted to NDPERS within thirty-one (31 days) of birth or physical placement of the adopted child. If the membership application is not received in accordance with this provision, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date. Pursuant to N.D.A.C. §71-03-03-01, an Employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent(s) enroll.

D. Employees and/or dependents who previously declined coverage under this Benefit Plan will be able to enroll under this Benefit Plan if each of the following conditions are met:
   1. During the initial enrollment period the employee or dependent states, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment at such time.
   2. The employee's or dependent's coverage under a group health plan or other health insurance coverage:
      a. was either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours, loss as a result of having a subsequent opportunity for late enrollment [including the Annual Enrollment Period] or special

enrollment under the Benefit Plan but again choosing not to enroll, or employer contributions toward such coverage were terminated; or

b. was under COBRA and the coverage was exhausted.

3. The employee requests such enrollment within thirty-one (31) days after the exhaustion or termination of coverage.

The effective date of coverage for an employee and/or dependent that previously declined coverage under this Benefit Plan, and is enrolling pursuant to this provision, will be the first of the month following the exhaustion or termination of the employee's and/or dependent's previous coverage. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

If the membership application is not received in accordance with this provision, and the Employee or Dependent is a Late Enrollee, the Late Enrollee's effective date of coverage will be the Group's anniversary date.

E. Employees and/or Dependents will be able to enroll under this Benefit Plan if either of the following conditions is met:

1. The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act, or under a state child health plan under Title XXI of the Social Security Act, and the employee's or dependent's coverage under such a plan is terminated as a result of loss of eligibility. The employee must request enrollment within sixty (60) days of the date of termination of coverage; or
2. The employee or dependent becomes eligible for premium assistance under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of the Social Security Act. The employee must request enrollment within sixty (60) days of the date the employee or dependent is determined to be eligible for premium assistance.

   The effective date of coverage under this Benefit Plan for an employee and/or dependent enrolling pursuant to this provision will be the first day immediately following the termination of coverage or eligibility for premium assistance. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

F. In accordance with the decision of the Supreme Court of the United States on June 26, 2015, in *Obergefell v. Hodges*, 576 U.S. (2015), regarding same-sex marriage:

1. **Same-sex marriages that occurred prior to June 26, 2015:** NDPERS will have a special enrollment period from July 1, 2015 through September 30, 2015. Coverage will be effective retroactive to July 1, 2015. If the Subscriber does not enroll during this eligibility period, the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st.
2. **Same-sex marriages that occur on or after June 26, 2015:** The Subscriber must submit an application for coverage within the first thirty-one (31) days of the event. If the Subscriber does not enroll when initially eligible, the Late Enrollee can only enroll during the next scheduled Annual Enrollment Period with coverage effective the following January 1st.

Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the Employee's Eligible Dependent is enrolled.

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

* *Voluntarily terminating/dropping COBRA coverage before it runs out outside Annual 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.

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

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

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

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

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

1.12 MICHELLE'S LAW

Federal law requires that we provide the following notice regarding Michelle's Law [Public Law 110-381]. Please note that changes in federal law may eliminate certain elements of Michelle's Law, and the Plan intends to provide continuing coverage of Eligible Dependents up to age twenty-six (26), irrespective of their student status, for Plan Years beginning on or after September 23, 2010.

A Dependent Child under twenty-five (25) years old and enrolled in and attending an accredited college, university, or trade or secondary school at least five (5) months each year will remain covered if the Dependent takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

1. Be medically necessary;
2. Commence while the child is suffering from a serious illness or injury; and
3. Cause the child to lose coverage under the plan.

Students are only eligible as long as they were covered by their parent's health insurance Certificate prior to diagnosis. Coverage will continue until the earlier of one year from the first day of the leave of absence or the date on which coverage would otherwise terminate because the child no longer meets the requirements to be an Eligible Dependent (e.g., reaching the plan's limiting age).

You must provide a written and signed certification from the Dependent Child's treating Practitioner and/or Provider stating that the Dependent Child is suffering from a serious illness or injury and that the leave of absence is medically necessary and the effective date of the leave.

SECTION 2
HOW YOU GET CARE

2.1 IDENTIFICATION CARDS

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

If you do not receive your ID card within *thirty* (30) calendar days after the effective date of your enrollment, you need a temporary card or replacement cards, please call us at (800) 499-3416 | TTY/TDD: 711 *(toll-free)* or write to us at Sanford Health Plan, ATTN: NDPERS, PO Box 91110 Sioux Falls, SD 57109-1110. You may also request replacement cards by signing into your account at sanfordhealthplan.com/memberlogin. Information on creating an account is available at sanfordhealthplan.com/ndpers.

2.2 CONDITIONS FOR COVERAGE

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

- Medically Necessary and/or Preventive;
- Received from or provided under the orders or direction of a Participating Provider;
- Approved by the Plan, including Preauthorization/Prior Approval where required; and
- Within the scope of health care benefits covered by the Plan.

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

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

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

In addition, all Health Care Services are subject to:

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

2.3 IN-NETWORK COVERAGE

In-Network coverage is provided under two (2) plan levels. For more information, see *Selecting a Health Care Provider* in Section 3.7 In-Network benefit payments pay according to coverage under:

1. Basic Plan; or
2. PPO Plan

Note: If you travel out of the Plan's Service Area for the purpose of seeking medical treatment outside the Plan's Service Area, as defined in this COI, without Preauthorization/Prior Approval for a service that requires such authorization/approval, your claims will be paid according to the Basic Plan benefits and stipulations set forth in Section 3.7.
Additionally, the Member will receive Basic Plan benefits if: 1) a PPO Health Care Provider is not available in the Member's area; or 2) if the Member either chooses or is referred to a Health Care Provider not participating in the Preferred Provider Organization (PPO).

For *Appropriate Access* standards, see below.

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

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

2.4 APPROPRIATE ACCESS

Primary Care Physicians and Hospital Providers
Appropriate access for Participating Practitioner and/or Providers who provide primary care services and Hospital Provider sites is within *fifty* (50) miles of a Member's city of legal residence.

Specialty Practitioners and Providers
For other Participating Practitioner and/or Providers such as Specialty Physicians, Diagnostic Service Centers, Nursing Homes, and Rehabilitation Providers, appropriate access is within *fifty* (50) miles of a Member's city of legal residence. If you are traveling within the Service Area where other Participating Practitioner and/or Providers are available, then you must use Participating Practitioner and/or Providers.

Members who live outside of the Plan's Service Area must use the Plan's contracted Network of Participating Practitioners and Providers as indicated in the Plan's Provider Directory. Members who live outside the Service Area will receive Identification Cards that display their network logo along with instructions on how to access this Network. If a Member chooses to go to a Non-Participating Practitioner or Provider when appropriate access (within *fifty (50)* miles of a Member's city of legal residence) is available, claims will be processed at the Basic Plan (Out-of-Network) level.

Transplant Services

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

2.5 CASE MANAGEMENT

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

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

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

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

In consultation with case managers, Sanford Health Plan may approve coverage that extends beyond the limited time period and/or scope of treatment initially approved. This consultation also includes utilization management processes as described below.

All decisions made through case management are based on the individual circumstances of a Member's case. Each case is reviewed on its own merits by appropriate health plan medical professionals to ensure the best health outcome(s) of the Member.

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

2.6 BENEFIT DETERMINATION REVIEW PROCESS

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

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

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

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

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

2.8 ROUTINE POST-SERVICE BENEFIT REQUESTS

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

2.9 UTILIZATION MANAGEMENT REVIEW PROCESS

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

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

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

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

Designating an Authorized Representative

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

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

Your Right to Information

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

Your Complaint (Grievance) & Appeal Rights

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

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

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

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

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

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

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

- The Member's medical information, including diagnosis, medical history and the presence of complications and/or comorbidities.
- Consultation with the treating Practitioner and/or Provider, as appropriate.
- Availability of resources and alternate modes of treatment. For admissions to Facilities, other than Hospitals, additional information may include but is not limited to history of present illness, patient

treatment plan and goals, prognosis, staff qualifications and *twenty-four* (24) hour availability of qualified medical staff.

- Sanford Health Plan does not compensate Practitioners, Providers or other individuals conducting Utilization Review for issuing denials of coverage or service care. Any financial incentives offered to Utilization Review decision makers do not encourage decisions that result in underutilization and do not encourage denials of coverage or service.

Prior authorization is required for all inpatient admissions.

This requirement applies, but is not limited to, the following:

1. Acute care Hospitalizations (including medical, surgical, and non-emergency mental health or substance use disorder inpatient admissions);
2. Residential Treatment Facility admissions; and
3. Rehabilitation center admissions.

Admission before the day of non-Emergency surgery will not be authorized unless the early admission is Medically Necessary and specifically approved by Sanford Health Plan. Coverage for Hospital expenses prior to the day of surgery will be denied unless authorized prior to being incurred.

Referrals to Recommended Providers
Referrals to Non-Participating Providers, which are recommended by Participating Providers. Preauthorization/Prior Approval is required for the purposes of receiving Basic Plan level coverage. If Preauthorization/Prior Approval is not obtained for referrals to Non-Participating Providers, the services will be covered at the Basic Plan level. Preauthorization/Prior Approval does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in this section.

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

2.11 PHARMACY PRE-APPROVAL (CERTIFICATION) REQUESTS

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

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

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

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

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

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

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

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

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

Routine/Standard Pharmacy Pre-Approval Requests

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

Urgent Pharmacy Pre-Approval Requests

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

How to Request Pre-Approval for a Drug

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

- Contacting Pharmacy Management
- Complete Formulary Exception Form found online at sanfordhealthplan.com
- Ask the prescribing Practitioner and/or Provider for a letter of medical necessity
- Ask the prescribing Practitioner and/or Provider to contact the Plan by phone

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

Notification of the Decision (Determination)

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

2.12 ADDITIONAL INFORMATION REGARDING FORMULARY EXCEPTION REQUESTS

1. For contraceptives not in the Formulary, if the prescribing Practitioner and/or Provider determines that a drug/device is Medically Necessary and an exception to the formulary is granted, the contraceptive drug/device will be covered at Member's cost-share.
2. If the decision is to approve a standard (routine) Formulary exception request, the Plan will provide coverage of the non-Formulary drug for the duration of the prescription, including refills. If a request is granted based on an emergent circumstance, Sanford Health Plan will provide coverage of for the duration of the incident.
3. In the event that an exception request is granted, Sanford Health Plan will treat the excepted drug(s) as an essential health benefit, including, if applicable per the Member's Policy, counting any cost-sharing towards the Member's annual limitation on cost-sharing and when calculating the actuarial value.

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

2.13 MEDICAL PRE-APPROVAL (CERTIFICATION) REQUESTS

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

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

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

Routine Pre-Service Pre-Approval Requests

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

Urgent Pre-Service Pre-Approval Requests

Urgent pre-service requests for services that require pre-approval from the Plan will be reviewed as soon as possible and no later than **seventy-two (72) hours** after receipt of the request. Requests will be considered urgent if the Member's health is in serious jeopardy, or the Member's Practitioner and/or Provider states the Member may experience severe pain that cannot be controlled while waiting for the Plan's decision. If the request does not meet the definition of urgent, or is for a service that has already occurred, (post-service/retrospective) the request will be processed as a routine/standard request.

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

Emergent Medical Conditions

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

How to Request Pre-Approval for a Medical Item or Health Care Service
Refer to the Introduction section at the beginning of this document for instructions on contacting the Utilization Management department to request a medical pre-approval request.

What to Include with a Pre-Approval Request

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

Lack of Necessary Information

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

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

Notification of the Decision (Determination)

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

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

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

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

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

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

Determinations by us to Limit or Reduce Previously Approved Care

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

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

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

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

Requests to Extend Previously Approved Care

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

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

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

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

For requests to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, Sanford Health Plan shall make a determination and orally notify the Member, or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service, of the determination as soon as possible, taking into account the Member's medical condition, but in no event more than seventy-two (72) hours after the date of Sanford Health Plan's receipt of the request.

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

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

Non-Urgent (Standard) Concurrent Reviews

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

Urgent (Expedited) Concurrent Reviews

If your request for additional care is urgent, and if your Provider submits it no later than twenty-four (24) hours before the end of your pre-approved stay or course of treatment, Sanford Health Plan will make the decision as soon as possible (taking into account the medical exigencies) but no later than seventy-two (72) hours after receiving the request]. For authorizations and denials, we will give telephone notification of the decision to Members, Practitioners and those Providers involved in the provision of the service within seventy-two (72) hours of receipt of the request. We will give oral, written or electronic notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service as soon as possible but no later than within three (3) calendar days of the oral notification.

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

Adverse Determinations

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

Lack of Necessary Information

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

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

2.15 WRITTEN NOTIFICATION PROCESS FOR ADVERSE DETERMINATIONS

The written notifications for Adverse Determinations will include the following:

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

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

3. Notice of an Adverse Determination will include information sufficient to identify the claim involved, including the date of service the Provider, the claim amount (if applicable) and a statement notifying

members of their opportunity to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not be (and is not) considered a request for an internal appeal or external review;

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

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

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

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

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

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

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

10. You have the right to contact the North Dakota Insurance Commissioner at any time.
(Refer to the Introduction section at the beginning of this document for contact information.)

SECTION 3
COVERED SERVICES – OVERVIEW

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

3.1 HEALTH CARE SERVICES PROVIDED BY PRACTITIONERS AND PROVIDERS

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

- *All benefits for authorized services are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.*
- *Benefits will be denied if the Member is not eligible for coverage under this benefit plan on the date services are provided. Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *For a list of Limited and Non-Covered Services, see Section 4; Limited and Non-Covered Services*
- *Your Practitioner and/or Provider must get Certification of some services in this Section.* ***Receipt of Prior Authorization (Certification) does not guarantee payment of benefits.*** *The benefit description will say "**NOTE**: Certification is required for certain services. Failure to get Certification will result in a reduction or denial of benefits (See Services Requiring Certification in Section 2.).*

3.1.1 ARTIFICIAL NUTRITION

NOTE: This requires Certification; failure to get Certification may result in a reduction or denial of benefits *(See Services requiring Certification in Section 2.)*. Coverage is subject to Sanford Health Plan Guidelines.

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

3.1.2 ALLERGY CARE BENEFITS

- Testing and treatment
- Allergy injections
- Allergy serum

3.1.3 CHIROPRACTIC SERVICES

Covered when provided on an inpatient or outpatient basis when Medically Necessary as determined by Sanford Health Plan and within the scope of licensure and practice of a Chiropractor, to the extent

services would be covered if provided by a Physician. Benefits are not available for Maintenance Care.

3.1.4 CLINICAL TRIALS

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

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

3.1.5 DIABETES SUPPLIES, EQUIPMENT AND EDUCATION BENEFITS

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

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

Coverage for the treatment of diabetes includes:

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

3.1.6 DIAGNOSTIC AND TREATMENT SERVICES

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

3.1.7 DIALYSIS BENEFIT

- Dialysis for renal disease, unless or until the Member qualifies for federally funded dialysis services under the End Stage Renal Disease (ESRD) program.
- Services include equipment, training, and medical supplies required for effective dialysis care. See Outpatient Nutrition Care Services in this Section for additional Chronic Renal Failure benefits. Coordination of Benefit (COB) Provisions apply. For more information on COB, please see Section 6.

3.1.8 DURABLE MEDICAL EQUIPMENT (DME) BENEFITS

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

3.1.9 EYE CARE SERVICES

- Cataract Surgery.
    - One (1) pair of eyeglasses or contact lenses per Member when purchased within 6 months following a covered cataract surgery the surgery
- Eyeglasses or contact lenses for Members diagnosed with aphakia (the absence of the lens of the eye, due to surgical removal, a perforated wound or ulcer, or a congenital condition resulting in complications which include the detachment of the vitreous or retina, and glaucoma)
    - Eyeglasses, including lenses and one frame per lifetime up to a net allowance of $200 or clear contact lenses for the aphakia eye will be covered for two (2) single lens per Calendar Year
    - Scleral Shells: Soft shells limited to two (2) per Calendar Year. Hard shells limited to one (1) per lifetime
- Non-routine vision exams relating to disease or injury of the eye.
- Vision therapy for Members 17 and under; limited to 16 visits per calendar year

3.1.10 FOOT CARE SERVICES

- Routine foot care covered for Members with diabetes only.
- Non-routine diagnostic testing and treatment of the foot due to illness or injury

NOTE: See Section on Orthotic and prosthetic devices for information on podiatric shoe inserts

3.1.11 HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES)

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

- Benefit is limited to one hearing aid, per ear, per Adult Member, every three (3) years, in alignment with Medical Necessity and Sanford Health Plan guidelines with prior approval *(certification required)*.
    - External hearing aids for the treatment of a hearing loss that is not due to the gradual deterioration that occurs with aging and/or other lifestyle factors. *This is a DME that requires Preauthorization/Prior Approval.*
        - The provision of hearing aids must meet criteria for rehabilitative and/or habilitative services coverage and either:
            - provide significant improvement to the Member within two (2) months, as certified on a prospective and timely basis by the Plan; or
            - help maintain or prevent deterioration in physical, cognitive, or behavioral function.
- Cochlear implants and bone-anchored (hearing aid) implants. *This is an Implant/Stimulator that requires Preauthorization/Prior Approval*
- Hearing aids for Members under age 18.
- Sudden sensorineural hearing loss (SSNHL), and diagnostic testing and treatment related to acute illness or injury.

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

3.1.12 HOME HEALTH SERVICES

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

Member must be home-bound to receive home health services. The following is covered if approved by the Plan in lieu of Hospital or Skilled Nursing Facility:

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

3.1.13 IMPLANTS/STIMULATORS

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

3.1.14 INFERTILITY BENEFITS

Benefits are available for services, supplies and medications related to artificial insemination (AI) and assisted reproductive technology (ART), includes gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI) or in vitro fertilization (IVF). Preauthorization/Prior Approval *is required for assisted reproductive technology for GIFT, ZIFT, ICSI and IVF.*

NOTE: Benefits are subject to a $500 Lifetime Infertility Services Deductible Amount and a $20,000 Lifetime Benefit Maximum Amount per Member. The Infertility Services Deductible Amount and any Member-paid coinsurance for infertility services do not apply toward the Out-of-Pocket Maximum Amount.

3.1.15 LAB, X-RAY AND OTHER DIAGNOSTIC TESTS

Coverage includes, but is not limited to, the following

- Blood tests
- Urinalysis
- Non-routine Pap tests
- Non-routine PSA tests
- Pathology
- X-rays
- PET Scans
- DEXA Scans
- Non-routine mammograms
- CT Scans/MRI
- Ultrasound
- Electrocardiogram (EKG)
- Electroencephalography (EEG)

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

3.1.16 NEWBORN CARE BENEFITS

A newborn is eligible to be covered from birth. Members must complete and sign the Plan's enrollment application form requesting coverage for the newborn within *thirty-one (31)* days of the infant's birth. For more information, see Section 1 on Enrollment and "*When and How Dependent Coverage Begins"*.

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

3.1.17 ONCOLOGY TREATMENT BENEFITS

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

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

coverage. *This is an Oncology Service/Treatment that requires Certification.*

- The same cost-sharing amounts apply for intravenously administered or injected cancer chemotherapy agents as for prescribed, orally-administered, anticancer medications used to kill or slow the growth of cancerous cells

3.1.18 ORTHOTIC AND PROSTHETIC DEVICES

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

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

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

3.1.19 OTHER TREATMENT THERAPIES NOT SPECIFIED ELSEWHERE

- Inhalation Therapy
- Non-Surgical, medically necessary treatment, of Gender Dysphoria (Gender Identity Disorder), including hormone therapy, mental/behavioral services, and laboratory testing to monitor the safety of continuous hormone therapy, per Plan guidelines (available upon request).
- Pheresis Therapy

3.1.20 OUTPATIENT NUTRITIONAL CARE SERVICES

Benefits are available for the following medical conditions:

- **Anorexia Nervosa** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Bulimia** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Chronic Renal Failure** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Diabetes Mellitus** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.
- **Gestational Diabetes** – Maximum Benefit Allowance of two (2) Office Visits per Member per Benefit Period.
- **Hyperlipidemia** – Maximum Benefit Allowance of two (2) Office Visits per Member per Benefit Period.
- **PKU** – Maximum Benefit Allowance of four (4) Office Visits per Member per Benefit Period.

3.1.21 OUTPATIENT REHABILITATIVE AND HABILITATIVE THERAPY SERVICES

Coverage is as follows for outpatient rehabilitative and habilitative therapy services, which include the management of limitations and disabilities, and services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function:

- **Physical Therapy:** Benefits are subject to medical necessity and performed by or under the direct supervision of a licensed Physical Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Occupational Therapy:** Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Necessary. Benefits are available when performed by or under the direct supervision of a licensed Occupational Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Speech Therapy:** Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Necessary. Benefits are available when performed by or under the direct supervision of a certified and licensed Speech Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Respiratory/Pulmonary Therapy:** Available when services are performed by or under the direct supervision of a registered respiratory care practitioner for the treatment, management, control and care of Members with deficiencies and abnormalities of the cardiorespiratory system. Services must be provided in accordance with an order from a Professional Health Care Provider.

- **Cardiac Rehabilitation Services:** Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital. Twelve (12) visits per Member per episode, limited to the following diagnosed medical conditions:
  - Myocardial Infarction
  - Coronary Artery Bypass Surgery
  - Coronary Angioplasty and Stenting
  - Heart Valve Surgery
  - Heart Transplant Surgery

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

See section 3.1.11 HEARING SERVICES (TESTING, TREATMENT, AND SUPPLIES).

3.1.23 PEDIATRIC (CHILD) VISION SERVICES

Not Covered

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

Phenylketonuria (PKU) Coverage is as follows:

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

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.

3.1.25 PRENATAL AND MATERNITY SERVICES

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

Covered maternity services include:

- Screening for gestational diabetes mellitus during pregnancy
  - Testing includes a screening blood sugar followed by a glucose tolerance test if the sugar is high.
  - Outpatient Nutrition Care Services available for gestational diabetes and diabetes mellitus. See
- 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 has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force unless excluded under "Not Covered" conditions below. *This is considered an Outpatient Service that requires Preauthorization/Prior Approval.*
- Prenatal vitamins without Cost Sharing if prescribed by a Practitioner
- Deductible for delivery services is waived if services are rendered at a PPO Provider, and the Member is enrolled in Sanford Health Plan's *Healthy Pregnancy Program*.

Maternity care includes prenatal through postnatal maternity care and delivery, and care for complications of pregnancy in the mother. We cover up to two (2) routine ultrasounds per pregnancy to determine fetal age, size, and development, per plan guidelines.

The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of *forty-eight (48)* hours for a vaginal delivery to a minimum of *ninety-six (96)* hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Practitioner and/or Provider, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If the inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by Participating Practitioners and/or Providers competent in postpartum care and newborn assessments.

Healthy Pregnancy Program

The *Healthy Pregnancy Program* is designed to provide you with the tools and support you need to give your baby the healthiest start possible. Participation in the *Healthy Pregnancy Program* is voluntary and free to all Plan Members.

As a program participant you will receive:

- Educational information on pregnancy, childbirth and postpartum
- Access to Text4baby, a tool to help remind you of doctor visits, personalized tips on prenatal care, baby's growth, signs of labor, nursing, eating habits and more
- Deductible waiver*
- Free prenatal vitamins
- Access to RN case manager to answer questions

After your first prenatal visit, Members may enroll in Sanford Health Plan's Healthy Pregnancy program starting their 8th week of pregnancy, but no later than the 34th week at **sanfordhealthplan.com/ndpers/healthy-pregnancy-program**. Members will need their Member

number, health care provider name, and expected due date. If you have questions, please contact our care management team Monday through Friday from 8 a.m. to 5 p.m. CST at (888) 315-0884 (TTY: 711).

NOTE: When a Member is enrolled under the Healthy Pregnancy Program, the Deductible Amount is waived for delivery services received from a PPO Health Care Provider. High Deductible Health Plan members may enroll in the program but will not receive the deductible waiver benefit.

Newborns' and Mothers' Health Protection Act Disclosure

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

NOTE: We encourage you to participate in our Healthy Pregnancy Program; Call (888) 315-0884 (toll-free) or TTY/TDD: 711 (toll-free) to enroll.

3.1.26 PREVENTIVE CARE, ADULTS & CHILDREN

A Health Care Provider will counsel Members as to how often preventive services are need based on the age**,** gender and medical status of the Member. Services include:

- **Well Child Care to the Member's 6th birthday**
  - Seven (7) visits for Members from birth through 12 months;
  - Three (3) visits for Members from 13 months through 24 months; and
  - One (1) visit per Benefit Period for Members 25 months through 72 months.
- **Well Child Care Immunizations to the Member's 6th Birthday**
  - Covered immunizations are those that have been published as policy by the Centers for Disease Control, including DPT (Diphtheria-Pertussis-Tetanus), MMR (Measles-Mumps-Rubella), Hemophilus, Influenza B, Hepatitis, Polio, Varicella (Chicken Pox), Pneumococcal Disease, Influenza Virus.
- **Preventive Screening Services for Members age 6 and older**
  - One routine physical examination per Member per Benefit Period.
  - Routine diagnostic screenings.
  - Routine screening procedures for cancer.
  - **Note:** The Plan will pay up to a Maximum Benefit Allowance of $200 per Member per Benefit Period for any *non-diagnostic screening services* not listed below. Such *non-diagnostic screening services* will be subject to Copayment, Deductible and Coinsurance amounts after the $200 Benefit Allowance has been met.
- **Mammography Screening Services**
  - One (1) screening service for Members between the ages of 35 and 40.
  - One (1) screening service per year per Members ages 40 and older.

    - Covered non-diagnostic mammography screening services are subject to deductible/coinsurance and are eligible for $200 routine screening benefit allowance.
- **Routine Pap Smear**
    - One (1) Pap smear per Member per Benefit Period. Office Visit Copay applies.
    - Additional benefits will be available for Pap smears when Medically Necessary and ordered by a Professional Health Care Provider.
- **Prostate Cancer Screening for the following: Asymptomatic Males Ages 50 and Older; Males ages 40 and Older of African American descent; and Males Ages 40 with a Family History of Prostate Cancer**
    - One (1) digital rectal examination annually per Member. Office Visit Copay applies.
    - One (1) prostate-specific antigen test annually per Member. Office Visit Copay applies.
    - Additional benefits will be available for prostate cancer screening when Medically Necessary and ordered by a Professional Health Care Provider.
- **Fecal Occult Blood Testing for Colorectal Cancer Screening for Members age 45 and older**
    - One (1) test per Member per benefit period.
    - Covered non-diagnostic colonoscopies are subject to deductible/coinsurance and are eligible for $200 routine screening benefit allowance.
- **Immunizations other than Well Child Care**
- Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including Tetanus, Influenza Virus, Pneumococcal Pneumonia, MMR (Measles-Mumps-Rubella), Varicella (Chicken Pox), Shingles (Zoster), Meningococcal Disease, and Human Papillomavirus (HPV). Certain age restrictions may apply

3.1.27 PRIVATE DUTY NURSING

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

- Private Duty Nursing is nursing care that is provided to a Member on a one-to-one basis by licensed nurse in an inpatient or home setting when any of the following are true:
    - No skilled services are already being provided.
    - Skilled nursing resources are available in the facility.
    - The skilled care can be provided by a Home Health Agency on a per visit basis for a specific purpose.
    - The service is provided to a Covered Person by an independent nurse who is hired directly by the Covered Person or his/her family. This includes nursing services provided on an inpatient or home-care basis, whether the service is skilled or non-skilled independent nursing.

3.1.28 TELEHEALTH SERVICES (VIRTUAL VISITS)

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

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

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

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

3.2 SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY

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

- *Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Policy and are payable only when we determine they are Medically Necessary.*
- *In-Network Participating Practitioner and/or Providers must provide or arrange your care and you must be hospitalized in a Network Facility.*
- *Mental Health and Substance Use Disorder benefits provided by a Hospital or other Facility are outlined in Section 3.4).*
- *For a list of Limited and Non-Covered Services, see Section 4; Limited and Non-Covered Services*
- *Be sure to read Section 2, How you get care, for valuable information about conditions for coverage.*
- *YOUR PRACTITIONER AND/OR PROVIDER MUST GET CERTIFICATION OF SOME OF THESE SERVICES.*

3.2.1 ADMISSIONS

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

The following Hospital Services are covered:

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

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

3.2.2 ANESTHESIA

SHP covers services of an anesthesiologist or other certified anesthesia Provider in connection with an authorized/approved procedure or treatment.

3.2.3 HOSPICE CARE

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

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

3.2.3 ORAL AND MAXILLOFACIAL SURGERY

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

- Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.*
    1. Care must be received within *twelve* (12) months of the occurrence
    2. Associated radiology services are included
    3. "Injury" does not include injuries to Natural Teeth caused by biting or chewing
    4. Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Orthognathic Surgery per Sanford Health Plan guidelines. *This is an Outpatient Surgery that requires Certification*
    1. Associated radiology services are included
    2. "Injury" does not include injuries to Natural Teeth caused by biting or chewing
    3. 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:
    1. Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
    2. Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
    3. TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
        - Splint limited to one (1) per Member per benefit period.
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
    1. is a child age nine (9) or older- *(Certification is not required for children under 9)*; or
    2. is severely disabled or otherwise suffers from a developmental disability; or
    3. has a high-risk medical condition(s) as determined by a licensed Physician that places the

Member at serious risk.

3.2.4 OUTPATIENT HOSPITAL OR AMBULATORY SURGICAL CENTER

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

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

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

3.2.5 RECONSTRUCTIVE SURGERY

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

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

3.2.6 SKILLED NURSING CARE FACILITY BENEFITS

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

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

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

3.2.7 TRANSPLANT SERVICES

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

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

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

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

3.3 EMERGENCY SERVICES/ACCIDENTS

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

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

3.3.1 BENEFIT DESCRIPTION

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

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

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

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

3.3.2 EMERGENCY WITHIN OUR SERVICE AREA

Emergency services from Basic Plan-level Providers will be covered at the same benefit and Cost Sharing level as services provided by PPO-level Providers both within and outside of the Sanford Health Plan Service Area in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. If the Plan determines the condition did not meet Prudent Layperson definition of an emergency, then the Basic Plan-level cost-sharing amounts will apply and the Member is responsible for charges above the Maximum Allowed Amount.

If an Emergency Condition arises, Members should proceed to the nearest emergency Facility that is an In-Network Participating Practitioner and/or Provider. If the Emergency Condition is such that a Member cannot go safely to the nearest participating emergency Facility, then the Member should seek care at the nearest emergency Facility. To find a listing of Participating Providers and Facilities, sign into your account at sanfordhealthplan.com/memberlogin or call the Plan toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)*.

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

3.3.3 PARTICIPATING EMERGENCY PROVIDERS/FACILITIES

The Plan covers Emergency services necessary to screen and stabilize Members without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts may apply, subject to whether services were received from a PPO-level or Basic-level Participating Provider/Facility, as set forth in Section 3.7. See Section 3.7, "*Participating Providers*" and "*How PPO vs. Basic Plan Determines Benefit Payment*" for details.

3.3.4 NON- PARTICIPATING EMERGENCY PROVIDERS/FACILITIES

The Plan covers Emergency services necessary to screen and stabilize a Member and may not require Prospective (Pre-Service) Review of such services if a Prudent Layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the Emergency, or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Providers set forth in Section 3.7, and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 3.7, "*Non-Participating Health Care Providers*", for more information.

If a Member is admitted as an inpatient to a Non-Participating Provider Facility, then the Plan will contact the admitting Practitioner and/or Provider to determine medical necessity and a plan for treatment. In some cases, where it is medically safe to do so, the Member may be transferred to a Participating Hospital and/or other appropriate Facility.

3.3.5 EMERGENCY OUTSIDE OUR SERVICE AREA

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

3.3.6 URGENT CARE SITUATION

Treatment provided in Urgent Care Situations from Basic Plan-level Providers will be covered at the same benefit and cost sharing level as services provided by PPO-level Providers both within and outside of the Sanford Health Plan Service Area in cases where a Prudent Layperson reasonably believed that an Urgent Care Situation existed.

NOTE: If the Plan determines the condition did not meet Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, and the Member is responsible for charges

above the Maximum Allowed Amount.

If an **Urgent Care Situation** occurs, Members should contact their Primary Care Practitioner and/or Provider immediately, if one has been selected, and follow his or her instructions. If a Primary Care Practitioner and/or Provider has not been selected, the Member should contact the Plan and follow the Plan's instructions. A Member may always go directly to a participating urgent care or after-hours clinic. To find a listing of Participating Providers and Facilities, sign into your account at sanfordhealthplan.com/memberlogin or call the Plan toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 *(toll-free)*.

3.3.7 PARTICIPATING PROVIDERS/FACILITIES

The Plan covers services in an Urgent Care Situation without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that an Urgent Care Situation existed.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts may apply, subject to whether services were received from a PPO-level or Basic-level Participating Provider/Facility, as set forth in Section 3.7. See Section 3.7, "*Participating Providers*" and "*How PPO vs. Basic Plan Determines Benefit Payment*" for details.

3.3.8 NON- PARTICIPATING PROVIDERS/FACILITIES

The Plan covers services in an Urgent Care Situation without Preauthorization/Prior Approval requirements if a Prudent Layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the Urgent Care Situation, or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

NOTE: If the Plan determines the Member's condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Providers set forth in Section 3.7, and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 3.7, "*Non-Participating Health Care Providers*", for more information.

3.3.9 AMBULANCE AND TRANSPORTATION SERVICES

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

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 the Plan.

3.4 MENTAL HEALTH AND SUBSTANCE USE DISORDER BENEFITS

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

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

3.4.1 MENTAL HEALTH BENEFITS

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

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

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

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

For outpatient treatment services, the **first five (5) visits of treatment** of any calendar year will be covered at 100% (no charge).

If you are having difficulty obtaining an appointment with a mental health practitioner and/or Provider, or for mental health needs or assessment services by phone, call the Sanford USD Medical Center Triage Line toll-free at (888) 996-4673.

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

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

3.4.2 APPLIED BEHAVIOR ANALYSIS FOR TREATMENT OF AUTISM SPECTRUM DISORDER

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

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

- Member must be diagnosed with Autism Spectrum Disorder by a Provider and/or Practitioner qualified to diagnose the condition.
- ABA as behavioral health treatment is expected to result in the achievement of specific improvements in the Member's functional capacity of their autism spectrum disorder, subject to Plan medical policy and medical necessity guidelines
- ABA services are only covered when provided by a licensed or certified practitioner as defined by law.
- Coverage of ABA is subject to preauthorization, concurrent review, and other care management requirements.
- Limits are subject to the Plan's medical management policies and determinations of Medical Necessity.

3.4.3 SUBSTANCE USE DISORDER BENEFITS

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

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

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

For outpatient treatment services, **the first five (5) visits of treatment** of any calendar year will be covered at 100% (no charge).

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

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

3.5 OUTPATIENT PRESCRIPTION DRUG BENEFITS

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

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

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

3.5.1 BENEFIT DESCRIPTION

You must fill the prescription at a Plan Participating pharmacy for Cost Sharing amounts to apply. A Member may be responsible for payment of the Cost Sharing Amounts at the time the Prescription Medication is dispensed. A Participating Pharmacy agrees not to charge or collect any amount from the Member that exceeds the Cost Sharing Amounts. All claims from a Participating Pharmacy must be submitted by the Participating Pharmacy. A listing of the Plan's Participating pharmacies is available by contacting the Plan or online at sanfordhealthplan.com/ndpers. Specialty pharmacy options include any in network pharmacy, there is no specialty pharmacy requirement.

If a Member receives Prescription Medications from a Non-Participating Pharmacy, the Member is responsible for submitting a Claim for Benefits. Charges in excess of the Allowed Charge are the Member's responsibility.

- To fill a prescription, you must present your ID card to your pharmacy, if you do not, you will be responsible for all (100%) of the costs of the prescription to the pharmacy. Additionally, if you choose to go to a Non-Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy.

NOTE: If a Member receives Prescription Medications from a Non-Participating Pharmacy, the Member is responsible for payment of the Prescription Order or refill in full at the time it is dispensed and to submit appropriate reimbursement information to Sanford Health Plan. Payment for covered Prescription Medications will be sent to the Subscriber. Any charges in excess of the Allowed Charge are the Subscriber's responsibility.

- Sanford Health Plan uses a formulary: a list of prescription drug products, which are covered by the Plan for dispensing to Members when appropriate. The formulary will be reviewed regularly, and medications may be added or removed from the Formulary throughout the year. The Plan will notify you of the changes as they occur. For a copy of the Plan Formulary, contact Pharmacy Management or log in to your Member Portal at www.sanfordhealthplan.com/memberlogin.
- Sanford Health Plan reserves the right to maintain a drug listing of medications that are not available/excluded for coverage per Plan medical necessity and limitation guidelines. Payment for excluded medications will be the Member's responsibility in full. Members may request an appeal

(review of an Adverse Determination) based on medical necessity for Non-Covered medications. For details, refer to the appeals section of this Certificate of Insurance.

- Sanford Health Plan will use appropriate Pharmacists and Practitioner and/or Providers to review formulary exception requests and promptly grant an exception to the formulary for a Member when that the prescriber indicates:
  - the Formulary drug causes an adverse reaction in the Member;
  - the Formulary drug is contraindicated for the Member; or
  - the prescription drug must be dispensed as written to provide maximum medical benefit to the Member.
- **NOTE**: To request a Formulary exception, please call Pharmacy Management or send a request by logging into the provider portal at www.sanfordhealthplan.com/memberlogin.
- Members must first try formulary medications before an exception to the formulary will be made unless the prescriber and the plan determine that use of the formulary drug may cause an adverse reaction or be contraindicated for the Member. If an exception is granted, coverage of the non-formulary drug will be provided for the duration of the prescription, including refills. See Pharmaceutical Review Requests and Exception to the Formulary Process in Section 2 for details.
- With certain medications, the Plan requires a trial of first-line medications, typically generics, before more expensive name brand medications are covered. If the desired clinical effect is achieved or a side effect is experienced, then a second line medication may be tried. If a step therapy rule is not met at the pharmacy, coverage will be determined by Prior Authorization (pre-approval) Review. Request Prior Authorization by contacting Pharmacy Management. Refer to the Formulary for a complete list of medications that require step therapy.
- To be covered by the Plan, certain medications require prior authorization (pre-approval) to ensure medical necessity. This can be in the form of written or verbal certification by a prescriber. To request certification, contact Pharmacy Management. Refer to the formulary for a complete list of medications that require Prior Authorization.
- Certain medications have a quantity limit to ensure the medication is being used as prescribed and the member is receiving the most appropriate treatment based on manufacturer's safety and dosing guidelines. Refer to your formulary for a complete list of medications with quantity limits.

There are dispensing limitations.

- One (1) Copayment Amount, plus any applicable coinsurance amount, applies per Prescription Order or refill for a *1 – 34-day* supply.
- Two (2) Copayment Amounts, plus any applicable coinsurance amounts, apply per Prescription Order or refill for a *35 – 100-day* supply. Prescription Medications and nonprescription diabetes supplies are subject to a dispensing limit of a *100-day* supply.
- Prescription refills will be covered when 75% of your prescription has been used up with a surplus limit of 10 days. The surplus limit is calculated based on the amount of medication obtained over the previous 180 days and limits you to a maximum of 10 days of additional medication at any given time.
- Specialty Medications can be filled to a 30-day supply per copay (or less, if prescribed) at one time (unless otherwise approved by the Plan).

- If you traveling on vacation and need an extra supply of medication, you may request a "vacation override" to receive up to a three (3) month's supply of medication. Vacation supplies are limited to the time period that the Member is enrolled in the plan and one vacation override per medication per calendar year. Please contact Pharmacy Management to request a vacation override.
- If you receive a brand name drug when there is a generic equivalent or biosimilar alternative available, you will be required to pay a brand penalty. The brand penalty consists of the price difference between a brand name drug and the generic equivalent or biosimilar alternative, in addition to applicable cost sharing (copay and/or deductible/coinsurance) amounts. Brand penalties do not apply to your deductible or maximum out of pocket.

3.5.2 COVERED MEDICATIONS AND SUPPLIES

To be covered by the Plan, prescriptions must be:

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

3.5.3 COVERED TYPES OF PRESCRIPTIONS

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 such as subcutaneous injections, oral or topical medications, or nebulized inhalation are to be obtained from a Network Pharmacy
3. Medicinal substances (legally restricted medications) that may only be dispensed by a prescription, according to applicable laws and regulations
4. Compounded medications are only covered when the medication has at least one ingredient that is a federal legend or state restricted drug in a therapeutic amount.
5. Diabetic supplies, such as insulin, a blood glucose meter, blood glucose test strips, continuous glucose monitor receiver, diabetic needles and syringes are covered when medically necessary. (See section 3.1 for Diabetic supplies, equipment, and self-management training benefits.)
6. Generic oral contraceptives, injections and/or devices will be subject to Member's cost-share.

3.6 DENTAL BENEFITS

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

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

3.6.1 BENEFIT DESCRIPTION

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

- Dental services provided by a Dentist (D.D.S.) in an office setting as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face. *This is considered an Outpatient Surgery or Service that requires Certification.*
  - Covered Services must be initiated within 12 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by Sanford Health Plan is in place.
  - Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth
  - Associated radiology services are included
  - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
  - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
  - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
  - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
    - Splint limited to one (1) per Member per benefit period.
- Diagnosis and treatment for craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
  - is a child age nine (9) or over; (Certification not required for children under 9) 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.
- Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Coverage applies to stabilization related to accident or injury only and not restoration.

3.6.2 PEDIATRIC (CHILD) DENTAL CARE

Not covered

3.7 SCHEDULE OF BENEFITS

3.7.1 GENERAL

This section outlines the payment provisions for Covered Services described in Sections 3 and 5, subject to the definitions, exclusions, conditions and limitations of this Benefit Plan.

3.7.2 OVERVIEW OF COST SHARING AMOUNTS AND HOW THEY ACCUMULATE

Cost Sharing Amounts include Coinsurance, Copayment, and Deductibles; as well as the Prescription Drug Out-of-Pocket Maximum, Infertility Services Deductible and Out-of-Pocket Maximum Amounts. See *Cost Sharing Amounts – Details & Definitions* later in this Section for more information.

- The Deductible Amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, accumulate jointly up to the PPO Deductible Amount.
- The Out-of-Pocket Maximum Amounts for Covered Services received from a PPO Health Care Provider or on the Basic Plan, accumulate jointly up to the Out-of-Pocket Maximum Amount.
- When the PPO Out-of-Pocket Maximum Amount has been met, all Covered Services received from a PPO Health Care Provider will be paid at 100% of Allowed Charge. Covered Services sought under the Basic Plan will continue to be paid at 75% of the Allowed Charge until the Out-of-Pocket Maximum Amount for Basic Plan services is met.
- Prescription Medication Cost Sharing Amounts do not apply toward the Medical Out-of-Pocket Maximum Amounts.
- Prescription Medication Cost Sharing Amounts apply toward the Prescription Drug Out-of-Pocket Maximum Amounts.

A Member is responsible for Cost Sharing Amounts. All Members in the family contribute to Deductible and Coinsurance Amounts. However, a Member's contribution cannot be more than the Single Coverage amount. Health Care Providers may bill you directly or request payment of Coinsurance, Copayment and Deductible Amounts at the time services are provided. For the specific benefits and limitations that apply to this Plan, please see Section 3.8, *Outline of Covered Services*; Section 3, *Covered Services*; Section 4, *Limited and Non-Covered Services*; and your Summary of Benefits and Coverage.

If Sanford Health Plan pays amounts to the Health Care Provider that are the Member's responsibility, such as Deductibles, Copayments or Coinsurance Amounts, Sanford Health Plan may collect such amounts directly from the Member. The Member agrees that Sanford Health Plan has the right to collect such amounts from the Member.

3.7.3 BENEFIT SCHEDULE

Benefit Schedule	PPO Plan	Basic Plan
Under this Benefit Plan the Deductible Amounts are:		
Single Coverage	$500 per Benefit Period	$500 per Benefit Period
Family Coverage	$1,500 per Benefit Period	$1,500 per Benefit Period
Under this Benefit Plan the Coinsurance Maximum Amounts are:		
Single Coverage	$1,000 per Benefit Period	$1,500 per Benefit Period
Family Coverage	$2,000 per Benefit Period	$3,000 per Benefit Period
Under this Benefit Plan the Out-of-Pocket Maximum Amounts are:		
Single Coverage	$1,500 per Benefit Period	$2,000 per Benefit Period
Family Coverage	$3,500 per Benefit Period	$4,500 per Benefit Period
Under this Benefit Plan the Prescription Drug Out-of-Pocket Maximum Amount is:		
$1,200 per Member per Benefit Period Cost-sharing for non-formulary medications does not apply to the $1,200 Out-of-Pocket Maximum		
Under this Benefit Plan the Lifetime Infertility Services Deductible Amount is:		
$500 per Member		

The benefit payment available under this Benefit Plan differs depending on the Subscriber's choice of a Health Care Provider. This Benefit Plan recognizes the following categories of Health Care Providers based on the Health Care Provider's relationship with Sanford Health Plan. Providers that are contracted with Sanford Health Plan, and participate in the Plan's Network, will be paid at either the PPO Plan or Basic Plan level.

Members should refer to the Sanford Health Plan website (sanfordhealthplan.com/ndpers) for the Provider Directory, which lists Participating Health Care Providers. The Sanford Health Plan website is continuously updated and has the most up-to-date listing of Health Care Providers. Members may also call Customer Service at (800) 499-3416 *(toll-free)* or TTY/TDD: 711 *(toll-free)* to request a provider directory.

3.7.4 HOW PPO VS. BASIC PLAN DETERMINES BENEFIT PAYMENT

PPO Plan

PPO stands for "Preferred Provider Organization" and is a group of Health Care Providers who provide discounted services to the Members of NDPERS. Because PPO Health Care Providers charge Sanford Health Plan less for medical care services provided to the Members of NDPERS, cost savings are passed on to Members by way of reduced Cost Sharing Amounts.

To receive a higher payment level, Covered Services must be received from an NDPERS PPO Health Care Provider. Please see the NDPERS PPO Health Care Provider Listing at sanfordhealthplan.com/ndpers.

NOTE: Benefits for Covered Services received by Eligible Dependents, as outlined in Section 2, *Eligibility Requirements for Dependents*, who are residing out of the state of North Dakota will be paid at the Basic Plan level. If the Subscriber, or the Subscriber's spouse, is required by court order to provide health coverage for that Eligible Dependent, you may be asked to provide a copy of the court order to the Plan.

Basic Plan
If a PPO Health Care Provider is: 1) not available in the Member's area; or 2) if the Member either chooses or is referred to a Health Care Provider not participating in the Preferred Provider Organization (PPO), the Member will receive the Basic Plan benefits.

3.7.5 PARTICIPATING HEALTH CARE PROVIDERS

When Covered Services are received from a Participating Health Care Provider, the Participating Health Care Provider agrees to submit claims to Sanford Health Plan on behalf of the Member. Reimbursement for Covered Services will be made directly to the Participating Health Care Provider according to the terms of this Benefit Plan and the participation agreement between the Health Care Provider and Sanford Health Plan.

When Covered Services are received from a Participating Health Care Provider (health care providers who are contracted with Sanford Health Plan), a provider discount provision is in effect. This means the Allowance paid by Sanford Health Plan will be considered by the Participating Health Care Provider as payment in full, except for Cost Sharing Amounts, or if applicable, Maximum Benefit Allowances or Lifetime Maximums.

Participating Health Care Providers have also agreed to perform managed benefits requirements on behalf of the Member. If the Health Care Provider is a Participating Health Care Provider, as defined in Section 10, the benefit payment will be as indicated in the Outline of Covered Services and the Member's Summary of Benefits and Coverage (SBC).

3.7.6 NON- PARTICIPATING HEALTH CARE PROVIDERS

If a Member receives Covered Services from a Non-Participating Health Care Provider (health care providers who are not contracted with Sanford Health Plan), the Member will be responsible for notifying Sanford Health Plan of the receipt of services. If Sanford Health Plan needs copies of medical records to process the Member's claim, the Member is responsible for obtaining such records from the Non-Participating Health Care Provider.

3.7.7 NON-PARTICIPATING HEALTH CARE PROVIDERS WITHIN THE STATE OF NORTH DAKOTA

If a Member receives Covered Services from a Non-Participating Health Care Provider within the state of North Dakota, benefit payments will be based on the Allowance and reduced by an additional 20%. The 20% payment reduction does not apply toward the Out-of-Pocket Maximum Amount. The Allowance will not exceed 80% of the billed charge.

NOTE: The Member is responsible for the 20% payment reduction and any charges in excess of the Allowance for Covered Services.

Benefit payments will be made directly to the Provider for Covered Services received from a Non-Participating Health Care Provider. Sanford Health Plan may designate a Health Care Provider as Non-Payable.

3.7.8 NON-PARTICIPATING HEALTH CARE PROVIDERS OUTSIDE THE STATE OF NORTH DAKOTA

If a Member receives Covered Services from a Non-Participating Health Care Provider outside the state of North Dakota, the Allowance for Covered Services will be an amount within a general range of payments made and judged to be reasonable by Sanford Health Plan.

NOTE: The Member is responsible for any charges in excess of the Allowance for Covered Services.

If a Member receives Covered Services from a Health Care Provider in a county contiguous to North Dakota, the benefit payment will be provided on the same basis as a Health Care Provider located in the state of North Dakota. If the Health Care Provider is a Participating Health Care Provider, the benefit payment will be as indicated in the Outline of Covered Services and SBC. If the Health Care Provider is not a Participating Health Care Provider, benefits will be available at the same level as Non-Participating Health Care Providers within the state of North Dakota. Sanford Health Plan may designate a Health Care Provider as Non-Payable.

3.7.9 NON-PARTICIPATING PROVIDERS OUTSIDE THE SANFORD HEALTH PLAN SERVICE AREA

When Covered Services are provided outside of Sanford Health Plan's Service Area by health care providers who have not entered into a "participating agreement" with Sanford Health Plan (Non-Participating Health Care Providers), the amount the Member pays for such services will generally be based on either Sanford Health Plan's Non-Participating Health Care Provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Sanford Health Plan will make for the Covered Services as set forth in this paragraph.

In certain situations, Sanford Health Plan may use other payment bases, such as the payment Sanford Health Plan would make if the Covered Services had been obtained within the Sanford Health Plan Service Area, or a special negotiated payment, as permitted, to determine the amount Sanford Health Plan will pay for Covered Services provided by Non-Participating Health Care Providers. In these situations, a Member may be liable for the difference between the amount that the Non-Participating Health Care Provider bills and the payment Sanford Health Plan will make for the Covered Services as set forth in this paragraph.

3.7.10 HEALTH CARE PROVIDERS OUTSIDE THE UNITED STATES

The benefits available under this Benefit Plan are also available to Members traveling or living outside of the United States. The same Preauthorization/Prior Approval requirements will apply. If the Health Care Provider is a Participating Provider, the Participating Health Care Provider will submit claims for reimbursement on behalf of the Member. Reimbursement for Covered Services will be made directly to the Participating Health Care Provider. If the Health Care Provider is not a Participating Provider, the Member will be responsible for payment of services and submitting a claim for reimbursement to Sanford Health Plan. Sanford Health Plan will provide translation and currency conversion services for the Member's claims outside of the United States.

Sanford Health Plan will reimburse Prescription Medications purchased outside the United States by Members who live outside the United States where no suitable alternative exists. Reimbursement will also be made in instances where Members are traveling and new drug therapy is initiated for acute conditions or where emergency replacement of medications originally prescribed and purchased in the United States is necessary. The reimbursable supply of medications in travel situations will be limited to an amount necessary to assure continuation of therapy during the travel period and for a reasonable period thereafter.

3.7.11 NON-PAYABLE HEALTH CARE PROVIDERS

If Sanford Health Plan designates a Health Care Provider as *Non-Payable*, no benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of the *Non-Payable Health Care Provider*. Notice of designation as a Non-Payable Health Care Provider will be provided to Members at least 30 days prior to the effective date of designation as a Non-Payable Health Care Provider.

As of the date of termination, all charges incurred by a Member for services received from the Non-Payable Health Care Provider will be the Subscriber's responsibility.

3.7.12 MEDICARE PRIVATE CONTRACTS

A Health Care Provider may ask a Member who is eligible for Medicare to enter into a Medicare private contract where the Member and the Health Care Provider agree that the Member is to be provided with services outside of the Medicare program. This Medicare private contract must be entered into between the Member and the Health Care Provider prior to the receipt of any services, and indicate that 1) neither the Member nor the Health Care Provider is permitted to file a request for reimbursement with Medicare for any of the services provided by the Health Care Provider; and 2) the Health Care Provider can charge any amount agreed to by the Member for services instead of the Medicare limiting charge.

Under a Medicare private contract, the Health Care Provider can set any price for services but Medicare will not pay anything. If the Member enters into a Medicare private contract, Medicare will not pay any portion of the services and Sanford Health Plan will limit its payment to the amount Sanford Health Plan would have paid as though Medicare was paying for such Covered Services. If a Member enters into a Medicare private contract, the Member is responsible for paying the difference between the amount billed by the Health Care Provider for Covered Services and the amount paid by Sanford Health Plan.

3.7.13 COST SHARING AMOUNTS- DETAILS

A Cost Sharing Amount is the dollar amount a Member is responsible for paying when Covered Services are received from a Health Care Provider. Cost Sharing Amounts include Coinsurance, Copayment and Deductible Amounts. Applicable Cost Sharing Amounts are identified in Section 2 and the Member's Summary of Benefits and Coverage. See the schedule above in *Overview of Cost Sharing Amounts and how they accumulate* for the specific Cost Sharing Amounts that apply to this Benefit Plan.

3.7.14 COINSURANCE

Sanford Health Plan shall calculate Coinsurance Amounts on behalf of Members obtaining Covered Services within the Sanford Health Plan contracted provider network on the lesser of (1) billed charges or (2) provider negotiated payment rates (Allowed Charge).

If Covered Services are obtained by a Member out of the Sanford Health Plan contracted provider network, the coinsurance calculation may be based on the Health Care Provider's billed charges. This may result in a significantly higher Coinsurance Amount for certain services a Member incurs out of the Sanford Health Plan contracted provider network. It is not possible to provide specific information for each Health Care Provider outside of Sanford Health Plan's Service Area because of the many different arrangements between Health Care Providers. However, if a Member contacts Sanford Health Plan prior to receiving services from a Health Care Provider outside of Sanford Health Plan's Service Area, Sanford Health Plan may be able to provide information regarding specific Health Care Providers.

3.7.15 COINSURANCE MAXIMUM AMOUNTS

The total Coinsurance Amount that is a Member's responsibility during a Benefit Period. The Coinsurance Maximum Amounts renew on January 1 of each consecutive Benefit Period.

3.7.16 DEDUCTIBLES

The Deductible Amounts renew on January 1 of each consecutive Benefit Period. Copayment Amounts do not apply toward the Deductible Amount.

NOTE: The deductible amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, cross accumulate jointly up to the PPO Deductible Amount.

3.7.17 OUT-OF-POCKET MAXIMUM AMOUNTS

When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Covered Services, less Copayment Amounts incurred during the remainder of the Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1st of each consecutive Benefit Period. Prescription Medication Cost Sharing Amounts do not apply toward the Out-of-Pocket Maximum Amount.

NOTE: The Out-of-Pocket Maximum Amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, cross accumulate jointly up to the PPO Out-of-Pocket Maximum Amount.

NOTE: When the PPO Out-of-Pocket Maximum Amount has been met, all Covered Services received from a PPO Health Care Provider will be paid at 100% of Allowed Charge. Covered Services sought on a Basic Plan basis will continue to be paid at 75% of the Allowed Charge until the Out-of-Pocket Maximum Amount for Basic Plan services is met.

3.7.18 PRESCRIPTION DRUG OUT-OF-POCKET MAXIMUM AMOUNTS

When the Prescription Drug Out-of-Pocket Maximum Amount that is a Member's responsibility during a Benefit Period is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications, less Copayment Amounts incurred during the remainder of the Benefit Period. This Prescription Drug Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period.

3.7.19 INFERTILITY SERVICES COINSURANCE/DEDUCTIBLE

Neither the Infertility Services Lifetime Deductible Amount nor any Member-paid coinsurance for infertility services applies toward the annual Out-of-Pocket Maximum Amounts. Infertility services are limited per Member to a lifetime benefit maximum of $20,000.

3.8 OUTLINE OF COVERED SERVICES

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	Basic Plan After Deductible Amount
Inpatient Hospital and Medical Services		
• **Inpatient Hospital Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Inpatient Medical Care Visits**	80% of Allowed Charge.	75% of Allowed Charge.
• **Ancillary Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Inpatient Consultations**	80% of Allowed Charge.	75% of Allowed Charge.
• **Concurrent Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Initial Newborn Care**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
Inpatient and Outpatient Surgical Services		
• **Professional Health Care Provider Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Assistant Surgeon Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Ambulatory Surgical Facility Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Hospital Ancillary Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Anesthesia Services**	80% of Allowed Charge.	75% of Allowed Charge.
Transplant Services		
• **Inpatient and Outpatient Hospital and Medical Services**	80% of Allowed Charge *Preauthorization/Prior Approval required.*	75% of Allowed Charge *Preauthorization/Prior Approval required.*
• **Transportation Services**	80% of Allowed Charge. *Benefits are subject to a Maximum Benefit Allowance of $1,000 per transplant procedure.*	75% of Allowed Charge.
Dental Services	*Covered Dental Services Benefit is for stabilization related to accident or injury only and not restoration.*	
• **Temporomandibular (TMJ) or**	80% of Allowed Charge.	75% of Allowed Charge.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
Craniomandibular (CMJ) Joint Treatment	*Benefits are subject to a Maximum Benefit Allowance of 1 splint per Member per Benefit Period.*	
• **Dental Services Related to Accidental Injury**	80% of Allowed Charge.	75% of Allowed Charge.
• **Dental Anesthesia and Hospitalization**	80% of Allowed Charge. *Prior Approval is required for all Members age 9 and older.*	75% of Allowed Charge. *Prior Approval is required for all Members age 9 and older.*
Outpatient Hospital and Medical Services		
• **Home and Office Visits**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Diagnostic Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Emergency Services**	$60 Copayment Amount, then deductible and 80% of coinsurance applies for emergency room facility fee billed by a Hospital.	$60 Copayment Amount, then deductible and 80% of coinsurance applies for emergency room facility fee billed by a Hospital.
	The Copayment Amount for the emergency room facility fee is waived when a Member is admitted directly as an Inpatient to a Hospital.	
	80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider. (*Deductible Amount is waived)*	80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider. (*Deductible Amount is waived*
	80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.	80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
• **Ambulance Services**	80% of Allowed Charge.	80% of Allowed Charge.
• **Radiation Therapy and Chemotherapy**	80% of Allowed Charge.	75% of Allowed Charge.
• **Dialysis Treatment**	80% of Allowed Charge.	75% of Allowed Charge.
• **Home Infusion Therapy Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Visual Training for Members under age 17**	80% of Allowed Charge.	75% of Allowed Charge.
	Benefits are subject to an Annual Maximum of 16 visits per Member.	
• **Allergy Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Phenylketonuria (PKU) -** *Foods and food products for the dietary treatment of Members born after 12/31/62 with maple syrup urine disease or phenylketonuria (PKU)*	80% of Allowed Charge.	75% of Allowed Charge.
Wellness Services		
• **Well Child Care to the Member's 6th birthday**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available as follows:* • *7 visits for Members from birth through 12 months;* • *3 visits for Members from 13 months through 24 months; and* • *1 visit per Benefit Period for Members 25 months through 72 months.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Well Child Care Immunizations to the Member's 6th birthday**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
	Covered immunizations are those that have been published as policy by the Centers for Disease Control, including DPT (Diphtheria-Pertussis-Tetanus); MMR (Measles-Mumps-Rubella); Hemophilus; Influenza B; Hepatitis; Polio; Varicella (Chicken Pox); Pneumococcal Disease; and Influenza Virus.	

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Preventive Screening Services for Members age 6 and older**	\$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Benefits include:* • *One routine physical examination per Member per Benefit Period.* • *Routine diagnostic screenings.* • *Routine screening procedures for cancer.* *A Health Care Provider will counsel Members as to how often preventive services are needed based on the age, gender and medical status of the Member. The Plan will pay up to a Maximum Benefit Allowance of \$200 per Member per Benefit Period for any non-diagnostic screening services not listed below. Such non-diagnostic screening services will be subject to Copayment, Deductible and Coinsurance amounts after the \$200 Benefit Allowance has been met.*	\$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Mammography Screening Services**	100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available as follows:* • *One service for Members between the ages of 35 and 40* • *One service per year for Members age 40 and older.* *Additional benefits will be available for mammography services when Medically appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 3.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Routine Pap Smear**	100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are subject to a Maximum Benefit Allowance of 1 Pap smear per Benefit Period.*	100% of Allowed Charge. *Deductible Amount is waived.*
Related Office Visit	\$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Additional benefits will be available for Pap smears when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 3.*	\$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
• **Prostate Cancer Screening**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. Deductible Amount is waived.
Related Office Visit	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
Benefits are available for an annual digital rectal examination and an annual prostate-specific antigen test for the following: an asymptomatic male age 50 and older; a male age 40 and older of Africa American descent; and a male age 40 with a family history of prostate cancer *Additional benefits will be available for prostate cancer screening when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 3.*		
• **Fecal Occult Blood Testing for Colorectal Cancer Screening**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
Benefits are available for Members age 45 and older, subject to a Maximum Benefit Allowance for 1 test per Benefit Period.		
• **Immunizations other than Well Child Care**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including Tetanus, Influenza Virus, Pneumococcal Pneumonia, MMR (Measles-Mumps-Rubella), Varicella (Chicken Pox), Shingles (Zoster) Vaccine, Meningococcal Disease and Human Papillomavirus (HPV). Certain age restrictions may apply.		
• **Outpatient Nutritional Care Services**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
Benefits are available to the Maximum Benefit Allowance for the following diagnosed medical conditions: • *Hyperlipidemia – Two (2) Office Visits per Member per Benefit Period.* • *Gestational Diabetes – Two (2) Office Visits per Member per Benefit Period.* • *Chronic Renal Failure – Four (4) Office Visits per Member per Benefit Period.* • *Diabetes Mellitus – Four (4) Office Visits per Member per Benefit Period.* • *Anorexia Nervosa – Four (4) Office Visits per Member per Benefit Period.* • *Bulimia – Four (4) Office Visits per Member per Benefit Period.* • *PKU – Four (4) Office Visits per Member per Benefit Period.* • *Obesity – One (1) Office Visit per Member per Benefit Period.*		

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Diabetes Education Services**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
• **Dilated Eye Examination** *(for diabetes related diagnosis)*	$30 Copayment Amount, then 80% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount, then 75% of Allowed Charge. *Deductible Amount is waived.*
Outpatient Therapy Services Only the Office Visit Copayment Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider.		
• **Physical Therapy**	$30 Copayment Amount per Office Visit/Evaluation or $25 Copayment Amount Per Therapy/Modality, then 80% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit/Evaluation or $30 Copayment Amount Per Therapy/Modality, then 75% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are subject to the medical guidelines established by Sanford Health Plan.	
• **Occupational Therapy**	$25 Copayment Amount per Therapy/Modality, then 80% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per Therapy/Modality, then 75% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• **Speech Therapy**	$25 Copayment Amount per Therapy/Modality, then 80% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per Therapy/Modality, then 75% of Allowed Charge. *Deductible Amount is waived.*
	Benefits are available for 90 consecutive calendar days per condition, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.	
• **Respiratory Therapy Services**	80% of Allowed Charge.	75% of Allowed Charge.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Cardiac Rehabilitation Services**	80% of Allowed Charge. *Deductible Amount is waived.* *Benefits are subject to a Maximum Benefit Allowance of 12 visits per Member per episode for the following diagnosed medical conditions:* • *Myocardial Infarction* • *Coronary Artery Bypass Surgery* • *Coronary Angioplasty and Stenting* • *Heart Valve Surgery* • *Heart Transplant Surgery* *Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital.*	75% of Allowed Charge. *Deductible Amount is waived.*
• **Pulmonary Rehabilitation Services**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
Chiropractic Services	Only the Office Visit Copayment Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider.	
• **Home and Office Visits**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Therapy and Manipulations**	$25 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*	$30 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*
• **Diagnostic Services**	80% of Allowed Charge.	75% of Allowed Charge.
Maternity Services	The Deductible Amount is waived for delivery services received from a PPO Health Care Provider when the Member is enrolled in the *Healthy Pregnancy* Program.	
• **Inpatient Hospital and Medical Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Prenatal and Postnatal Care**	80% of Allowed Charge. *Deductible Amount is waived.*	75% of Allowed Charge. *Deductible Amount is waived.*
• **One (1) Prenatal Nutritional Counseling visit per pregnancy**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Lactation Counseling**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
Infertility Services		
• **Diagnostics, Treatment, Office Visits, and Other Services**	80% of Allowed Charge. *Benefits are subject to a $500 Lifetime Infertility Services Deductible Amount and a $20,000 Lifetime Benefit Maximum Amount per Member. The Infertility Services Deductible Amount and any Member-paid coinsurance for infertility services do not apply toward the Out-of-Pocket Maximum Amount.*	80% of Allowed Charge.
Mental Health and Substance Use Disorder Treatment Services		
• **Mental Health Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	80% of Allowed Charge. *Preauthorization is required.*	75% of Allowed Charge. *Preauthorization is required.*
Outpatient	*For all Outpatient Services, 100% of the Allowed Charge (includes Copayment and Deductible/Coinsurance) is waived for the initial 5 visits, per Member per Benefit Period.*	
Office Visits	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
All Other Services, Including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*
Applied Behavioral Analysis (ABA) for Autism Spectrum Disorders	80% of Allowed Charge. *Preauthorization/Prior Approval is required.*	75% of Allowed Charge. *Preauthorization/Prior Approval is required.*

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	 Basic Plan After Deductible Amount
➢ **Substance Use Disorder Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	80% of Allowed Charge. *Preauthorization is required.*	75% of Allowed Charge. *Preauthorization is required.*
Outpatient	*For all Outpatient Services, 100% of Allowed Charge (includes Copayment and Deductible/Coinsurance) is waived for the initial 5 visits, per Member per Benefit Period.*	
Office Visits	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$35 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
All Other Services, Including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*
Other Services Not Previously Listed Above		
• **Skilled Nursing Facility Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Home Health Care Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Hospice Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Private Duty Nursing Services**	80% of Allowed Charge.	75% of Allowed Charge.
• **Medical Supplies and Equipment** - Home Medical Equipment - Prosthetic Appliances and Limbs - Orthotic Devices - Supplies for Administration of Prescription Medications other than the diabetes supplies specified in Prescription Drug Benefit – See Section 3.5 - Oxygen Equipment and Supplies - Ostomy Supplies - External Hearing aids	80% of Allowed Charge. *Limited to one hearing aid, per ear, per Member every 3 years. For Members ages 18 and older, excludes hearing aids to correct gradual hearing impairment or loss that occurs with aging and/or other lifestyle factors.*	75% of Allowed Charge.

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount
• **Eyeglasses or Contact Lenses** *(following a covered cataract surgery)*	80% of Allowed Charge. *Benefits are subject to a Maximum Benefit Allowance of 1 pair of eyeglasses or contact lenses per Member when purchased within 6 months following the surgery.*	75% of Allowed Charge.
Prescription Drug and Diabetes Supplies Benefits		
Retail and Mail Order		
Insulin and medical supplies for insulin dosing and administration		
➢ **Insulin and Glucagon** Formulary or Non-Formulary		
1-30 day supply	$25 copayment *Deductible amount is waived*	$25 copayment *Deductible amount is waived*
31-60 day supply	$50 copayment *Deductible amount is waived*	$50 copayment *Deductible amount is waived*
61-100 day supply	$75 copayment *Deductible amount is waived*	$75 copayment *Deductible amount is waived*
➢ **Testing Supplies** Formulary		
1-30 day supply	25% coinsurance with maximum of $25	25% coinsurance with maximum of $25
31-60 day supply	25% coinsurance with maximum of $50	25% coinsurance with maximum of $50
61-100 day supply	25% coinsurance with maximum of $75	25% coinsurance with maximum of $75
➢ **Testing Supplies** Non-Formulary		
1-30 day supply	50% coinsurance with maximum of $25	50% coinsurance with maximum of $25
31-60 day supply	50% coinsurance with maximum of $50	50% coinsurance with maximum of $50
61-100 day supply	50% coinsurance with maximum of $75	50% coinsurance with maximum of $75
➢ **Insulin pen needles and syringes** Formulary or Non-Formulary		
1-30 day supply	12% coinsurance with maximum of $25	12% coinsurance with maximum of $25
31-60 day supply	12% coinsurance with maximum of $50	12% coinsurance with maximum of $50
61-100 day supply	12% coinsurance with maximum of $75	12% coinsurance with maximum of $75
Formulary Prescription Medication		
➢ Generic	$7.50 Copayment Amount, then 88% of Allowed Charge. Benefits are subject to the Prescription Drug Out-of-Pocket Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*	
➢ Brand Name	$25 Copayment Amount, then 75% of Allowed Charge. Benefits are subject to the Prescription Drug Out-of-Pocket Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*	
Non-Formulary Medication		
Generic and Brand Name	$30 Copayment Amount, then 50% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. *Deductible Amount is waived.*	

Covered Services	PROVIDER OF SERVICE PPO Plan After Deductible Amount	PROVIDER OF SERVICE Basic Plan After Deductible Amount

Under this Benefit Plan the Prescription Drug Out-of-Pocket Maximum Amount for Formulary medications is:

——————————$1,200 per Member per Benefit Period ——————————

Copayment Amount Application

- One Copayment Amount per Prescription Order or refill for a 1 - 34-day supply.
- Two Copayment Amounts per Prescription Order or refill for a 35 - 100-day supply.
- Two Copayment Amounts per Prescription Order or refill for a 2- or 3-month supply of Non-Formulary contraceptives.

Formulary contraceptive medications obtainable with a Prescription Order are subject to Member cost share; this includes over-the-counter Plan-B, if obtained with a Prescription Order. Cost share will be applied equal to other drugs-Generic, Preferred and Non-preferred.

Copayment Amounts do not apply to the following nonprescription diabetes supplies: syringes, lancets, blood glucose test strips, urine test products and control solutions. Coinsurance still applies.

If a Generic Prescription Medication is the therapeutic equivalent for a Brand Name Prescription Medication, and is authorized by a Member's Health Care Provider, benefits will be based on the Allowance for the Generic equivalent. If the Member does not accept the Generic equivalent, the Member is responsible for the cost difference between the Generic and the Brand Name Prescription Medication and applicable Cost Sharing Amounts. For details, see Section 3.5.

Prescription Medication Cost Sharing Amounts do not apply toward the Member's Out-of-Pocket Maximum Amounts. Prescription Medications and nonprescription diabetes supplies are subject to a dispensing limit of a 100-day supply.

Cost Sharing Amounts are waived for generic federal legend prenatal vitamins when the member is enrolled in the Healthy Pregnancy program. Member will be responsible for copayment plus co-insurance for all brand name federal legend prenatal vitamins and generic federal legend vitamins, if not enrolled in the Healthy Pregnancy Program. For details, see Section 3.

SECTION 4
LIMITED AND NON-COVERED SERVICES

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

4.1 GENERAL MEDICAL EXCLUSIONS

1. A service that would similarly not be charged for in a regular office visit
2. Abortions, 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.
3. Additional refractive procedure (including lens) after coverage of initial lens at time of cataract correction.
4. Admissions to Hospitals performed only for the convenience of the Member, the Member's family, or the Member's Practitioner and/or Provider
5. Adult vision exams (routine)
6. All other hearing related supplies, purchases, examinations, testing or fittings
7. Alternative treatment therapies including, but not limited to: acupuncture, acupressure, massage therapy unless covered per plan guidelines under Women's Health and Cancer Rights Act of 1998 (WHCRA) for mastectomy/lymphedema treatment, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, or therapeutic touch.
8. Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.
9. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this COI.
10. Any expenses related to surrogate parenting, unless the surrogate is a Member
11. Any fraudulently billed charges or services received under fraudulent circumstances.
12. Any other equipment and supplies which the Plan determines are not eligible for coverage
13. Any services or supplies for the treatment of obesity that do not meet the Plan's medical necessity coverage guidelines, including but not limited to: dietary regimen (except as related to covered nutritional counseling), nutritional supplements or food supplements; and weight loss or exercise programs.
14. Appointment scheduling
15. Artificial organs, any transplant or transplant services not listed above
16. Autopsies, unless the autopsy is at the request of the Plan in order to settle a dispute concerning provision or payment of benefits. The autopsy will be at the Plan's expense
17. Bifocal contact lenses
18. Blood and blood derivatives replaced by the Member
19. Breastfeeding equipment and supplies (personal use)
20. Charges for duplicating and obtaining medical records from Non-Participating Providers unless requested by the Plan.
21. Charges for professional sign language and foreign language interpreter services.
22. Charges for sales tax, mailing, interest and delivery.
23. Charges for services determined to be duplicate services by the Plan's Chief Medical Officer or designee.
24. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner and/or Provider or electronic consultations
25. Charges that exceed the Maximum Allowed Amount for Non-Participating Providers.
26. Chemical peel for acne
27. Clarification of simple instructions
28. Cleaning and polishing of prosthetic eye(s)

29. Clinical ecology, orthomolecular therapy, vitamins (unless otherwise specified as covered in this COI) or dietary nutritional supplements, or related testing provided on an inpatient or outpatient basis.
30. Compact (portable) travel hemodialyzer system
31. Complications from a non-covered or denied procedure or service.
32. Confinement Services to hold or confine a Member under chemical influence when no Medically Necessary services are provided, regardless of where the services are received (e.g. detoxification centers)
33. Consultative message exchanges
34. Contraceptives that do not require a Prescription Order or dispensed by a Health Care Provider , including medications, devices, appliances, supplies and related services for contraception. All contraceptives requiring a Prescription Order or dispensed by a Healthcare Provider are covered, subject to Member's Cost Share.
35. Convalescent care
36. Cosmetic Services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services
37. Cosmetic Services and/or supplies to repair or reshape a body structure not Medically Necessary and/or primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, cosmetic dental services, body contouring procedures, and body lift procedures, with the exception of WHCRA for coverage related to breast cancer.
38. Costs related to locating and/or screening organ donors
39. Coverage is limited to one (1) piece of same-use equipment (e.g. mobilization, suction), unless replacement is covered under the replacement guidelines in this policy. Duplicate or back up equipment is not a covered benefit.
40. Custodial or Convalescent care
41. Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized/approved corrective surgery (except as stated above and in Section 3 "Diabetes supplies, equipment, and education")
42. Deluxe equipment
43. Dental appliances of any sort, including but not limited to bridges, braces, and retainers (except for appliances for treatment of TMJ/TMD)
44. Dental x-rays or dental appliances
45. Diagnosis and treatment of weak, strained, or flat feet
46. Dietary desserts and snack items
47. Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined
48. Domiciliary care or Maintenance Care
49. Donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of embryos sperm or eggs; Surrogate pregnancy and delivery; Gestational Carrier pregnancy and delivery; and preimplantation genetic diagnosis testing;
50. Donor expenses for complications that occur after sixty (60) days from the date the organ is removed, regardless of whether the donor is covered as a Member under this Plan
51. Duplicate or similar items
52. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management.
53. Educational or non-medical services for learning disabilities and/or behavioral problems, including those educational or non-medical services provided under the Individuals with Disabilities Education

Act (IDEA)

54. Elective health services received outside of the United States.
55. Expenses incurred by a Member as a donor, unless the recipient is also a Member
56. Experimental and Investigational Services.
57. Experimental and/or Investigational services or devices
58. 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.
59. Extraction of wisdom teeth
60. Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specified as Covered elsewhere in this Certificate of Insurance
61. Fees associated with Room and Board, unless Prior Authorization is received pursuant to Medical Necessity guidelines
62. First aid or precautionary equipment such as standby portable oxygen units
63. Food items for medical nutrition therapy
64. Food items for medical nutrition therapy (except as specifically allowed in the Covered Benefits Section of this Certificate of Insurance).
65. For Members ages 18 and older, external hearing aids; non-implant devices; or equipment to correct gradual hearing impairment or loss that occurs with aging and/or other lifestyle factors
66. Formula and supplements available Over the Counter
67. Genetic testing when performed in the absence of symptoms or high risk factors for a heritable disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices; genetic testing that has been performed in response to direct-to-consumer marketing and not under the direction of the Member's Practitioner and/or Provider.
68. Hair plugs or hair transplants
69. Health Care Services Covered by Any Governmental Agency/Unit for military service-related injuries/diseases, unless applicable law requires the Plan to provide primary coverage for the same.
70. 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
71. Health Care Services for sickness or injury sustained in the commission of a felony, unless source of injury is a result of domestic violence or a medical condition.
72. Health Care Services ordered by a court or as a condition of parole or probation
73. Health Care Services performed by any Provider who is the Member or a member of the Member's immediate family, including any person normally residing in the Member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only Participating Provider in the area, the Member may go to a Non-Participating Provider and receive In-Network coverage (Section 4). If the immediate family member is not the only Participating Provider in the area, the Member must go to another Participating Provider in order to receive coverage at the In-Network level.
74. Health Care Services prohibited state or federal rule, law, or regulation
75. Health Care Services provided either before the effective date of the Member's coverage with the Plan or after the Member's coverage is terminated.
76. Health Care Services that the Plan determines are not Medically Necessary.
77. Hemodialysis machine (not separately payable)
78. Home Modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment
79. Home Traction Units
80. Hospitalization for extraction of teeth if not otherwise specified as Covered in this Certificate of Insurance
81. Hot/cold pack therapy including polar ice therapy and water circulating devices

82. Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools
83. Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas
84. Iatrogenic condition, illness, or injury as a result of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error. Charges related to Iatrogenic illness or injury are not the responsibility of the Member.
85. Incidental cholecystectomy performed at the time of weight loss surgery.
86. Independent nursing, homemaker services, respite care
87. Installation or maintenance of any telecommunication devices or systems
88. Intermediate level or Domiciliary care
89. Items which are primarily educational in nature or for vocation, comfort, convenience or recreation
90. LASIK eye surgery
91. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics.
92. Low protein modified food products or medical food for PKU to the extent those benefits are available under a Department of Health program or other state agency
93. Maintenance and service fee for capped-rental items
94. Maintenance care
95. Maintenance Care that is typically long-term, by definition not therapeutically necessary but is provided at regular intervals to promote health and enhance the quality of life; this includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment, to prevent symptomatic deterioration or initiated by Members without symptoms in order to promote health and to prevent further problems
96. Marriage counseling; pastoral counseling; financial or legal counseling; and custodial care counseling
97. Methods of desensitization treatment: provocation/neutralization therapy for food/chemical or inhalant allergies by sublingual, intradermal and subcutaneous routes, Urine Autoinjections, Repository Emulsion Therapy, Candidiasis Hypersensitivity Syndrome Treatment or IV Vitamin C Therapy (unless otherwise specified as covered in this COI).
98. Milieu therapy
99. Natural teeth replacements including crowns, bridges, braces or implants
100. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events. Participating Providers are not permitted to bill Members for services related to such events. not to be eligible for coverage
101. Newborn delivery and nursery charges for adopted dependents prior to the adoption bonding period (See Section 1, "When and How Dependent Coverage Begins.")
102. Nursing care requested by, or for the convenience of the Member or the Member's family (rest cures)
103. Orthopedic shoes; over-the-counter orthotics and appliance, except if covered elsewhere in this Certificate of Insurance
104. Osseointegrated implant surgery (dental implants)
105. Personal comfort items (telephone, television, guest meals and guest beds)
106. Physical examinations, including but not limited to: pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for drivers' licenses)
107. PKU dietary desserts and snack items
108. Procedures to evaluate and reverse sterilization
109. Provider-initiated e-mail
110. Purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically covered elsewhere
111. Radial Keratotomy, Myopic Keratomileusis, and any surgery involving corneal tissue for the purpose of

altering, modifying, or correcting myopia, hyperopia, or stigmatic error
112. Refractive errors of the eye
113. Refractive eye surgery when used in otherwise healthy eyes to replace eyeglasses or contact lenses
114. Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other health care services
115. Reminders of scheduled office visits
116. Remote control devices as optional accessories
117. 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
118. Replacement of lost, stolen, broken, or damaged lenses or glasses
119. Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness; or if lost or stolen
120. Replacement or repair of items, if the items are damaged or destroyed by the Member's misuse, abuse or carelessness, lost, or stolen
121. Requests for a referral
122. 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.
123. Residential care
124. Rest cures
125. Reversals of prior sterilization procedures; and
126. Revision of durable medical equipment, except when made necessary by normal wear or use
127. Revision/replacement of prosthetics (except as noted per Plan guidelines (available upon request)
128. Routine cleaning of Scleral Shells
129. Routine dental care and treatment
130. Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates
131. Self-help and adaptive aids are not a covered benefit, including assistive communication devices and training aids.
132. Sensitivity training
133. Sequela, which are primarily cosmetic that occur secondary to a weight loss procedure (e.g., Panniculectomy, breast reduction or reconstruction).
134. Service call charges, labor charges, charges for repair estimates
135. Services and supplies related to ridge augmentation, implantology, and Preventive vestibuloplasty
136. Services and/or travel expenses relating to a Non-Emergency Medical Condition
137. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home.
138. Services for excluded benefits
139. Services for which the Member has no legal obligation to pay or for which no charge would be made if the Member did not have health plan or insurance coverage.
140. Services not medically appropriate or necessary
141. Services not medically appropriate to do via telehealth
142. 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.
143. Services provided in the Member's home for convenience
144. Services related to environmental change
145. Services that are not Health Care Services.
146. Services that are the responsibility of a Third Party Payor or are not billable to health insurance
147. Services to assist in activities of daily living (ADLs)
148. Services, chemotherapy, radiation therapy (or any therapy that damaged the bone marrow), supplies,

medications and aftercare for, or related to, artificial or non-human organ transplants
149. Services, chemotherapy, supplies, medications and aftercare for or related to human organ transplants not specifically approved by the Plan's Chief Medical Officer or its designee
150. Services, chemotherapy, supplies, medications and aftercare for, or related to, transplants performed at a non-Plan Participating Center of Excellence
151. Shortening of the mandible or maxillae for cosmetic purposes
152. Sleep studies performed at a facility not accredited by the American Academy of Sleep Medicine
153. Smoking deterrents.
154. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability.
155. Special lens coating or lens treatments for prosthetic eyewear
156. Storage of stem cells, including storing umbilical cord blood of non-diseased persons, for possible future use
157. Subsequent surgeries when no tangible evidence of Medical Necessity or improved quality of life exists.
158. Surgical procedures that can be done in a Practitioner office setting (i.e. vasectomy, toe nail removal)
159. Take-home medications (Prescription medications provided to a Member at discharge are paid under the Prescription Drug Benefit. See Sections 2 and 3.5 for payment amount details.)
160. Telephone assessment and management services
161. The following allergy testing modalities: nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgG level testing for food allergies, general volatile organic screening test and mauve urine test.
162. Therapy and service animals, including those used for emotional or anxiety support
163. Thermograms or thermography
164. Tinnitus Maskers
165. Tobacco cessation medication
166. Transfers performed only for the convenience of the Member, the Member's family or the Member's Practitioner and/or Provider
167. Transmission fees
168. Transplant evaluations with no end organ complications
169. Transplants and pre and post-transplant services at Non-Participating Center Of Excellence Facilities
170. Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria
171. Treatment of gradual deterioration of hearing that occurs with aging and/or other lifestyle factors, and related adult hearing screening services, testing and supplies
172. Unspecified complication of kidney transplant
173. Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier
174. Virtual colonoscopies
175. Vitamins (unless otherwise specified as covered in this COI), minerals, therabands, cervical pillows, and hot/cold pack therapy including polar ice therapy and water circulating devices
176. Voluntary or involuntary drug testing unless a part of a Plan approved treatment plan
177. Wearable artificial kidney, each

4.2 GENERAL PHARMACY EXCLUSIONS

1. Any medication equivalent to an OTC medication except for drugs that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and only when prescribed by a health care Practitioner and/or Provider
2. B-12 injection (except for pernicious anemia)

3. Compound medications containing any combination of the following: Baclofen, Bromfenac, Bupivicaine, Cyclobenzaprine, Gabapentin, Ketamine, Ketoprofen or Orphenadrine
4. Compound medications with no legend (prescription) medication
5. Drug Efficacy Study Implementation ("DESI") drugs
6. Experimental or Investigational medications or medication usage pursuant to the Plan's medical coverage policies
7. Excluded medications from coverage that provide little or no evidence of therapeutic advantage over other products available.
8. Food supplements and baby formula (except to treat phenylketonuria (PKU) or otherwise required to sustain life), nutritional and electrolyte substances
9. Medical Cannabis and/or its equivalents
10. Medications and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless Provider certifies off-label use with a letter of Medical Necessity)
11. Medications for cosmetic purposes, including baldness, removal of facial hair, or pigmenting or anti-pigmenting of the skin
12. Medications not listed in the Plans Formulary
13. Medications obtained at a Non-Participating and/or Out-of-Network Pharmacy;
14. Medications that are obtained without Prior Authorization or a Formulary exception from the Plan
15. Medications that may be received without charge under a government program, unless coverage is required for the medication
16. Medications that provide little or no evidence of therapeutic advantage over other products available
17. Medications that require professional administration (may include: intravenous (IV) infusion or injection, intramuscular (IM) injections, intravitreal (ocular) injection, intra-articular (joint) injection, intrathecal (spinal) injections) will apply to the Member's medical benefit;
18. Orthomolecular therapy, including nutrients or vitamins unless otherwise specified as covered in this document
19. Over-the-counter (OTC) medications vitamins and/or supplements, equipment or supplies (except for insulin and select diabetic supplies, e.g., insulin syringes, needles, test strips and lancets) that by Federal or State law do not require a prescription order
20. Refills of any prescription older than one (1) year
21. Repackaged medications
22. Replacement of a prescription medication due to loss, damage, or theft
23. Self-administered medications dispensed in a Provider's office or non-retail pharmacy location
24. Unit dose packaging
25. Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia

4.3 SPECIAL SITUATIONS AFFECTING COVERAGE

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

- Complete or partial destruction of the Provider's facilities;
- Declared or undeclared acts of War or Terrorism;
- Riot;
- Civil insurrection;
- Major disaster;
- Disability of a significant portion of the Participating Providers;

- Epidemic; or
- A labor dispute not involving Participating Providers, we will use our best efforts to arrange for the provision of Covered Services within the limitations of available facilities and personnel. If provision or approval of Covered Services is delayed due to a labor dispute involving Participating Providers, Non-Emergency Care may be deferred until after resolution of the labor dispute.

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

4.4 SERVICES COVERED BY OTHER PAYORS

The following are excluded from coverage:

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

4.5 SERVICES AND PAYMENTS THAT ARE THE RESPONSIBILITY OF MEMBER

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

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

5.1 REIMBURSEMENT OF CHARGES BY PARTICIPATING PROVIDERS

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

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

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

5.2 REIMBURSEMENT OF CHARGES BY NON-PARTICIPATING PROVIDERS

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

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

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

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

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

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

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

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

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

5.3 PAYMENTS FOR AIR AMBULANCE CHARGES

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

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

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

5.4 BALANCE BILLING FROM NON-PARTICIPATING PROVIDERS

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

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

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

5.5 HEALTH CARE SERVICES RECEIVED OUTSIDE OF THE UNITED STATES

Deductible and applicable cost-share will apply for Medically Necessary emergency and urgent care services received in a foreign country. There is no coverage for elective or preventive Health Care Services if a Member or their dependent(s) travels to another country for the purpose of seeking medical treatment outside the United States. There is no coverage for any non-emergent Health Care Services if a Member or their dependent(s) resides in another country.

5.6 TIMEFRAME FOR PAYMENT OF CLAIMS

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

5.7 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

5.8 MEMBER BILL AUDIT PROGRAM

Upon receiving notice of a claims payment, or Explanation of Benefits (EOB), from Sanford Health Plan, Members are encouraged to audit their medical bills and notify the Plan of any services which are improperly billed or of services that the Member did not receive.

If, upon audit of a bill, an error of $40 or more is found, the Member will receive a minimum payment of $20 or 50% of the resulting savings for paid Covered Services up to a maximum payment of $500.

To obtain payment through the Member Bill Audit Program, the Member must complete a *Member Bill Audit Refund Request Form*. To obtain a form, sign into your account at sanfordhealthplan.com/memberlogin or call Sanford Health Plan Customer Service toll-free at (800) 499-3416 | TTY/TDD: 711 *(toll-free)* and request a form be mailed to you.

NOTE: This program does not apply when the NDPERS Benefit Plan is the secondary payor on a claim. For more information on claims with more than one payor, see Section 6, *Coordination of Benefits*.

SECTION 6
COORDINATION OF BENEFITS

NOTE: Sanford Health Plan follows North Dakota Administrative Code §45-08-01.2-03 regarding Coordination of Benefits (COB). The COB provision applies when a person has health care coverage under more than one "plan" as defined for COB purposes.

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

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

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

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

6.1 APPLICABILITY

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

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

The benefits of this Plan:

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

6.2 DEFINITIONS (FOR COB PURPOSES ONLY)

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

a) Group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of Group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes medical care components of long-term care contracts, such as skilled nursing care; medical benefits coverage in Group, Group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts; and Medicare or any other federal governmental plan, as permitted by law.

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). Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified

disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

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

"**This Plan**" refers to this certificate, which provides benefits for health care expenses and means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

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

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

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

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

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

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

6.3 ORDER OF BENEFIT DETERMINATION RULES

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

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

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

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

- secondary to the Plan covering the person as a Dependent; and

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

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

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

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

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

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

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

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

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

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

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

6.4 EFFECT OF COB ON THE BENEFITS OF THIS PLAN

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

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

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

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

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

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

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

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

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

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

6.5 CALCULATION OF BENEFITS, SECONDARY PLAN

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

6.6 COORDINATION OF BENEFITS WITH GOVERNMENT PLANS AND BENEFITS

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

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

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

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

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

Medicare generally pays for most or all of these expenses.

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

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

6.7 COORDINATION OF BENEFITS WITH MEDICARE

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

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

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

When MSP Rules Apply to COB

Medicare Coordination of Benefits provisions apply when a Member has health coverage under this Certificate of Insurance and is enrolled for insurance under Medicare, Parts A and BThis provision applies before any other Coordination of Benefits Provision of this Certificate of Insurance.

Coordination with Medicare Part D

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

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

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

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

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

When Medicare is primary despite the MSP rules:

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

  *** 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.*

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

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

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

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

allowable amount. Sanford Health Plan pays the difference between what Medicare pays and Sanford Health Plan's allowable expense.

6.8 MEMBERS WITH END STAGE RENAL DISEASE (ESRD)

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

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

How Primary vs. Secondary is Determined:

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

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

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

6.9 COORDINATION OF BENEFITS WITH MEDICAID

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

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

6.10 COORDINATION OF BENEFITS WITH TRICARE

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

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

- TRICARE-eligible employees and beneficiaries receive primary coverage under this Certificate of Insurance in the same manner, and to the same extent, as similarly situated employees of the Plan Sponsor (Employer) who are not TRICARE eligible.

The Plan does not:

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

SECTION 7
SUBROGATION AND RIGHT OF REIMBURSEMENT

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

Subrogation Defined

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

Reimbursement Defined

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

Covered Individuals

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

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

7.1 SANFORD HEALTH PLAN'S RIGHTS OF SUBROGATION

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

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

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

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

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

7.2 SANFORD HEALTH PLAN'S RIGHT TO REDUCTION AND REIMBURSEMENT

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

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

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

7.3 ERRONEOUS PAYMENTS

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

7.4 MEMBER'S RESPONSIBILITIES

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

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

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

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

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

7.5 SEPARATION OF FUNDS

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

7.6 PAYMENT IN ERROR

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

SECTION 8
HOW COVERAGE ENDS

8.1 TERMINATION BY THE SUBSCRIBER

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

8.2 TERMINATION, NONRENEWAL, OR MODIFICATION OF MEMBER COVERAGE

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

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

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

Notification

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

Uniform Modification of Coverage

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

8.3 MEMBER APPEAL OF TERMINATION

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

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

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

8.4 TERMINATION OF MEMBER COVERAGE

For the purposes of this Benefit Plan, upon termination of Member Coverage, the following provisions control:

1. **Determining Ineligibility.** Eligibility for benefits subsequent to retirement or termination will be determined pursuant to N.D.C.C. §54-52.1-03.
2. **Continuation of health, dental, vision, or prescription drug coverage after termination.** An employee who terminates employment and is not receiving a monthly retirement benefit from one of the eligible retirement systems, and applies for continued coverage with the health, dental, vision, or prescription drug plan may continue such coverage for a maximum of eighteen (18) months by remitting timely payments to the Board. The employee desiring coverage shall notify the Board within sixty (60) days of the termination. Coverage will become effective on the first day of the month following the last day of coverage by the employing agency, if an application is submitted within sixty (60) days. An individual who fails to timely notify the board is not eligible for coverage. [N.D.A.C. §71-03-03-06]
3. **Continuation of health, dental, vision, or prescription drug coverage for dependents.** Dependents of employees with family coverage may continue coverage with the group after their eligibility would ordinarily

cease. This provision includes divorced or widowed spouses and children when they are no longer dependent on the employee. Coverage is contingent on the prompt payment of the premium, and in no case will coverage continue for more than thirty-six (36) months. Dependents desiring coverage shall notify the board within sixty (60) days of the qualifying event and must submit an application in a timely manner. An individual who fails to notify the Board within the sixty (60) days, and who desires subsequent coverage, will not be eligible for coverage. [N.D.A.C. §71-03-03-07]

4. **Leave without pay.** An employee on an approved leave without pay may elect to continue coverage for the periods specified in the plans for life insurance, health, dental, vision, or prescription drug coverages by paying the full premium to the agency. An eligible employee electing not to continue coverage during a leave of absence is entitled to renew coverage for the first of the month following the month that the employee has returned to work if the employee submits an application for coverage within the first thirty-one (31) days of returning to work. An eligible employee failing to submit an application for coverage within the first thirty-one (31) days of returning to work or eligibility for a special enrollment period, may enroll during the annual open enrollment. Upon a showing of good cause, the executive director may waive the thirty-one day application requirement. [N.D.A.C. §71-03-03-09]
    a. In the event an enrolled eligible employee is not entitled to receive salary, wages, or other compensation for a particular calendar month, that employee may make direct payment of the required premium to the board to continue the employee's coverage, and the employing department, board, or agency shall provide for the giving of a timely notice to the employee of that person's right to make such payment at the time the right arises. [N.D.C.C. §54-52.1-06]

NOTE: A Member's coverage may not be terminated due to the status of the Member's health, or because the Member has exercised his or her rights, under the Plan's policy on member complaints, or the policy on appeal procedures for medical review determinations.

8.5 CONTINUATION

1. If the Subscriber becomes ineligible for group membership under this Benefit Plan due to an inability to meet NDPERS requirements and enrollment regulations, coverage will be canceled at the end of the last month that premium was received from the Plan Administrator. Exceptions may be made if:
    a. The Plan Administrator cancels coverage. Conversion coverage will not be offered to a Subscriber, if on the date of conversion, the Plan Administrator through which the Subscriber is eligible has terminated coverage with Sanford Health Plan, and the Plan Administrator has enrolled with another insurance carrier.
    b. The Plan Administrator no longer meets Sanford Health Plan's group coverage requirements. The Subscriber will be given the right to convert to a nongroup benefit plan, subject to premiums and benefit plan provisions in effect, if application for such coverage is made within 31 days after the termination date of the previous benefit plan.
    c. Ineligibility occurs because the Subscriber elects to discontinue employment, is terminated or is otherwise no longer covered under the group health plan. The Subscriber may elect continuation coverage through the Plan Administrator in accordance with state and federal law.
    d. Ineligibility occurs because the Subscriber is no longer eligible to continue coverage under the group (NDPERS). The Subscriber may elect conversion (individual) coverage on a nongroup basis, subject to premiums and benefit plan provisions for nongroup coverage then in effect, if the Subscriber applies for nongroup coverage within 31 days after the termination date of the previous group health plan coverage.

If a Member becomes otherwise ineligible for group membership under this Benefit Plan, Sanford Health Plan must at least offer the Subscriber its conversion (individual) benefit plan, if the Member lives in the Sanford Health Plan Service Area. There may be other coverage options for the Subscriber and/or Eligible Dependents 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." The cost of these options may vary

depending on a Subscriber's individual circumstances. To learn more, visit healthcare.gov or call (800) 318-2596 | TTY/TDD: (855) 889-4325.

8.6 EXTENSION OF BENEFITS FOR TOTAL DISABILITY

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

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

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

8.7 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 Members of the NDPERS Dakota Plan. It is the Plan Administrator's responsibility to notify Members of the termination of coverage.

8.8 NOTICE OF CREDITABLE COVERAGE

You may request a Certificate of Creditable Coverage for you and your covered family Members 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) 499-3416 | TTY/TDD: 711 *(toll-free)*. Written requests can be sent to memberservices@sanfordhealth.org or:

Sanford Health Plan
ATTN: NDPERS/Customer Service
PO Box 91110
Sioux Falls, SD 57109-1110

8.9 NOTICE OF GROUP TERMINATION OF COVERAGE

- **Termination due to Non-Renewal**

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

This notice will set forth at least the following:

- The effective date and hour of termination or of the decision to not renew coverage;
- The reason(s) for the termination or nonrenewal; and
- The Member's options listed below, including requirements for qualification and how to exercise the Member's rights:
    - the availability of Continuation of Coverage, if any; and

- the fact that the Member may have rights under federal COBRA provisions, independent from any provisions of This Contract, and should contact the Group for information on the COBRA provisions.

- **Termination due to Non-Payment of Premiums**

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

SECTION 9
OPTIONS AFTER COVERAGE ENDS

9.1 FEDERAL CONTINUATION OF COVERAGE PROVISIONS ("COBRA")

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

Introduction

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

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

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

What is COBRA Continuation Coverage?

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

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

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

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

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

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

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

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

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

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

When is COBRA Coverage Available?

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

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

For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 31 days after the qualifying event occurs. You must provide this notice to:

North Dakota Public Employees Retirement System
PO Box 1657
Bismarck, ND 58502
(701) 328-3900

How is COBRA Coverage Provided?

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

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a qualified beneficiary to receive a maximum of 36 months of coverage.**There are also ways in which this 18-month period of COBRA continuation coverage can be extended:**

Disability extension of 18-month period of COBRA continuation coverage

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

Second qualifying event extension of 18-month period of continuation coverage

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

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 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 healthcare.gov.

Keep Sanford Health Plan Informed of Address Changes

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

Plan Contact Information

Mail:	Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.
Phone:	(800) 752-5863 (toll-free) | TTY/TDD: 711 (toll-free)
	For free help in a language other than English: (800) 752-5863 (toll-free)
Fax:	(605) 328-6812
Online:	www.sanfordhealthplan.com/memberlogin

Or contact your employer.

SECTION 10
PROBLEM RESOLUTION

10.1 MEMBER APPEAL PROCEDURES - OVERVIEW

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

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

For information on medication/drug Formulary exception requests, see Sections 2.12 and 3.5, *Pharmaceutical Review Requests and Exception to the Formulary Process.*

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

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

Special Communication and Language Access Services

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

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

To contact Sanford Health Plan, a TTY/TDD line is available free of charge by calling toll-free 711. Please contact the Plan toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this COI or other written materials.

Help to understand this policy and your rights is free.
If you would like it in a different format (for example, in a larger font size),
please call us at (800) 499-3416 (toll-free).
If you are deaf, hard of hearing, or speech-impaired,
reach us at TTY/TDD: 711(toll-free).

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

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

10.2 DESIGNATING AN AUTHORIZED REPRESENTATIVE

You must act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. If you wish to designate an Authorized Representative, you must do so in writing. You can get a form by calling Customer Service toll-free at (800) 499-3416; or logging into your account at www.sanfordhealthplan.com/memberlogin. If a person is not properly designated in writing as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Policy.

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

10.3 AUDIT TRAILS

Audit trails for Complaints, Adverse Determinations and Appeals are provided by Sanford Health Plan's Information System and an Access database which includes documentation of the Complaints, Adverse Determination and/or Appeals by date, service, procedure, substance of the Complaint/Appeal (including any clinical aspects/details, and reason for the Complaint, Adverse Determination and/or Appeal.
The Appeal file includes telephone notification, and documentation indicating the date; the name of the person spoken to; the Member; the service, procedure, or admission certified; and the date of the service, procedure, or Adverse Determination and reason for determination. If Sanford Health Plan indicates authorization (Certification) by use of a number, the number will be called the "authorization number."

10.4 DEFINITIONS

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

- A determination of an individual's eligibility to participate in a plan;

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

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

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

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

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

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

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

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

In determining whether a request is "Urgent," Sanford Health Plan shall apply the judgment of a Prudent Layperson as defined in Section 8. A Practitioner, with knowledge of the Member's medical condition, who determines a request to be "Urgent," as defined in Section 8, shall have such a request treated as an Urgent Care Request by Sanford Health Plan.

10.5 COMPLAINT (GRIEVANCE) PROCEDURES

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

10.6 ORAL COMPLAINTS

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

10.7 WRITTEN COMPLAINTS

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

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

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

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

10.8 COMPLAINT INVESTIGATIONS

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

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

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

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

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

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

10.9 APPEAL PROCEDURES

Types of Appeals
Types of appeals include:

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

10.10 CONTINUED COVERAGE FOR CONCURRENT CARE

A Member is entitled to continued coverage for concurrent care pending the outcome of the appeals process; benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow the claimant to Appeal and obtain a review determination before the benefit is reduced or terminated. Review determinations would be made within twenty-four (24) hours.

10.11 INTERNAL APPEALS OF ADVERSE DETERMINATION (DENIAL)

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

Within one-hundred-eighty (180) days after the date of receipt of a notice of an Adverse Determination sent to a Member or the Member's Authorized Representative (as designated in writing by the Member), the Member or their Authorized Representative may file an Appeal with Sanford Health Plan requesting a review of the Adverse Determination. To Appeal, the Member may sign into their account at sanfordhealthplan.com/memberlogin and complete the "Appeal Filing Form" under the *Forms* tab. The Member or their Authorized Representative may also send a written Appeal to the Plan.

If the Member, Authorized Representative, Practitioner/Provider, and/or attorney, has questions, they are encouraged to contact the Plan. Customer Service is available to help with understanding information and processes. Alternate formats are also available and translation is available free of charge for written materials and Member communication with the Plan.

Refer to the Introduction section at the beginning of this document for instructions on how to contact the Customer Service Department.

10.12 APPEAL RIGHTS AND PROCEDURES

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

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

- In order to ensure the independence and impartiality of the persons involved in making claims determinations and appeals decisions, all decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.
- The attending Practitioner and/or Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Appeal within three (3) working days of receipt of the Appeal.
- Sanford Health Plan will provide notice of any Adverse Determination in a manner consistent with applicable federal regulations.

10.13 APPEAL NOTIFICATION TIMELINES

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

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

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

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

10.14 EXPEDITED INTERNAL APPEAL PROCEDURE

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

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the Appeal via telephone by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than within *seventy-two (72) hours* of receipt of the request. The Member and those Practitioners and/or Providers involved in the Appeal will receive written notification within *three (3) calendar days* of the telephone notification.

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

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

10.15 WRITTEN NOTIFICATION PROCESS FOR INTERNAL APPEALS

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

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

10.16 EXTERNAL PROCEDURES FOR ADVERSE DETERMINATIONS OF PHARMACEUTICAL EXCEPTION REQUESTS

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

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

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

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

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

10.17 STANDARD EXTERNAL REVIEW REQUEST PROCESSES & PROCEDURES

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

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

External Appeal Review Program – OVERVIEW

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

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

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

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

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

10.18 EXTERNAL APPEAL REVIEW PROGRAM PROCEDURES

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

- Members the right to an independent, third party, binding review whenever they meet the following eligibility criteria:
    - The Member is Appealing an Adverse Determination that is based on Medical Necessity (benefits Adverse Determinations are not eligible);
    - Sanford Health Plan has completed the internal Appeal review and its decision is unfavorable to the Member, or has exceeded the time limit for making a decision, or Sanford Health Plan has elected to bypass the available internal level of Appeal with the Member's permission;
    - The request for independent, External Review is filed within four (4) months of the date that Sanford Health Plan's Adverse Determination was made.
- Notification to Members about the independent, External Review program and decision are as follows:
    - General communications to Members, at least annually, to announce the availability of the right to independent, External Review.

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

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

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

- Conduct of the External Appeal Review program as follows:

  - A Member will contact Sanford Health Plan with an external review request.
  - Within five (5) business days following the date of receipt of the external review request, Sanford Health Plan shall complete a preliminary review of the request to determine whether:
  - The Member is or was a covered person at the time the health care service was requested or, in the case of a Retrospective Review, was a covered person in the Plan at the time the health care service was provided;
  - The health care service that is the subject of the Adverse Determination is a covered service under the Member's health benefit plan, but for a determination by the health carrier that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness;
  - The Member has exhausted Sanford Health Plan's internal Appeal process unless the Member is not required to exhaust Sanford Health Plan's internal Appeal process as defined above; and
  - The Member has provided all the information and forms required to process an external review.

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

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

- If the request is complete, within one (1) business day after verifying eligibility, the NDID shall assign an

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

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

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

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

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

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

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

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

for which the Member has already received an external review decision.

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

NOTE: All notifications and procedures described in this Section, in addition to those related to both Benefit and Medical Care Determinations in Section 2, will comply with applicable law. Should a conflict exist between Plan procedures and federal regulations, federal regulations shall control.

A complete description of your Complaint (Grievance) and Appeal Rights and the Appeal process will be included in determination responses and decisions made by Sanford Health Plan. Additionally, an overview of your Complaint (Grievance) and Appeal Rights, along with an Appeal Filing Form, is included in all Explanation of Benefits (EOBs) generated by Sanford Health Plan.

10.19 EXPEDITED EXTERNAL REVIEW REQUESTS

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

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

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

SECTION 11
DEFINITIONS OF TERMS WE USE IN THIS CERTIFICATE OF INSURANCE

Adverse Determination	Any of the following determinations: The denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination of a Member's eligibility to participate in the Plan; Any prospective review or retrospective Utilization Review determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit; or A rescission of coverage determination.
Affordable Care Act or ACA	The Patient Protection and Affordable Care Act, Public Law 111-148, as amended by the Healthcare and Education Reconciliation Act, Public Law 111-152, collectively referred to as the Affordable Care Act or ACA.
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 Member is discharged or released from the facility and is no longer registered as a patient. Also known as Hospitalization.
Allowance or Allowed Charge	The maximum dollar amount that payment for a procedure or service is based on as determined by Sanford Health Plan.
Ambulatory Surgical Center	A lawfully operated, public or private establishment that: 1. Has an organized staff of Practitioners; 2. Has permanent facilities that are equipped and operated mostly for performing surgery; 3. Has continuous Practitioner services and Nursing Services when a patient is in the Facility; and Does not have services for an overnight stay.
Annual Enrollment	A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan. Annual Enrollment does not pertain to non-Medicare retirees.
Authorized Representative	A person to whom a covered person has given express written consent to represent the Member, a person authorized by law to provide substituted consent for a Member, a family member of the Member or the Member's treating health care professional if the Member is unable to provide consent, or a health care professional if the Member'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 Member's medical condition.
Avoidable Hospital Conditions	Conditions that could reasonably have been prevented through application of evidence-based guidelines. These conditions are not present on admission, but present during the course of the stay. Participating Providers are not permitted to bill the Plan or Members for services related to Avoidable Hospital Conditions.

Basic Plan	The Member elects to access the health care system through a Health Care Provider that is not a part of the Preferred Provider Organization. Benefit payment will be at the Basic Plan level. Health Care Providers accessed at the Basic Plan level are also Participating Providers.
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.
Benefit Plan	The agreement with Sanford Health Plan, including the Subscriber's membership application, Identification Card, the Benefit Plan Agreement, this Certificate of Insurance, the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments
[The] Board	Means the North Dakota Public Employees Retirement System (NDPERS) board.
Calendar Year	A period of one year which starts on January 1st and ends December 31st.
Case Management	A coordinated set of activities conducted for individual patient management of chronic, serious, complicated, protracted, or other health conditions.
Certification	Certification is a determination by Sanford Health Plan that a request for a benefit has been reviewed and, based on the information provided, satisfies Sanford Health Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, and effectiveness.
Claims Administrator or Claims Payor	Sanford Health Plan
Class of Coverage	The type of coverage the Subscriber is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Classes of Coverage under this Benefit Plan are Single Coverage and Family Coverage.
Coinsurance Amount	A percentage of the Allowed Charge for Covered Services that is a Member's responsibility.
Coinsurance Maximum Amount	The total Coinsurance Amount that is a Member's responsibility during a Benefit Period. The Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period
Concurrent Review	Concurrent Review is Utilization Review for an extension of previously approved, ongoing course of treatment over a period of time or number of treatments typically associated with Hospital inpatient care including care received at a Residential Treatment Facility and ongoing outpatient services, including ongoing ambulatory care.
[This] Contract or [The] Contract	This Certificate of Insurance, which is a statement of the essential features and services given to the Subscriber by the Plan, including all attachments, the Group's application, the applications of the Subscribers and the Health Maintenance Contract.
Copayment (Copay)	A specified dollar amount payable by the Member for certain Covered Services. Health Care Providers may request payment of the Copayment Amount at the time of service.

Cosmetic	Surgery, medication, or other services performed for the primary purpose of enhancing or altering physical appearance without correcting, restoring or improving physiological function, or improving an underlying condition or disease.
Cost Sharing	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 doesn't 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 Member is entitled under the terms of This Contract.
Creditable Coverage	Benefits or coverage provided under: 1. A group health benefit plan (as such term is defined under North Dakota law); 2. A health benefit plan (as such term is defined under North Dakota law); 3. Medicare; 4. Medicaid; 5. Civilian health and medical program for uniformed services; 6. A health plan offered under 5 U.S.C. 89; 7. A medical care program of the Indian Health Service or of a tribal organization; 8. A state health benefits risk pool, including coverage issued under N.D.C.C. Chapter 26.1-08; 9. 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; 10. A health benefit plan under Section 5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and 11. A state's children's health insurance program funded through Title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].
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 Amount	A specified dollar amount payable by the Member for certain Covered Services received during the Benefit Period.
Dependent	The Spouse and any Dependent Child of a Subscriber.
Dependent Child	The definition of a Dependent Child of a Subscriber includes a child who is related to the Subscriber as a natural child, a child placed for adoption, a legally adopted child, a child for whom the Subscriber has legal guardianship, a stepchild, or a foster child; and is one of the following: (a) under the age of twenty-six (26), (b) incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within thirty-one (31) days of the Plan's request. If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility.

Dependent of Dependent	To be eligible for coverage, a dependent of the Subscriber's Dependent child, as defined above, must meet all the following requirements: 1. Be the natural child of the Subscriber's Dependent Child, a child placed with the Subscriber's Dependent Child for adoption, a legally adopted child by the Subscriber's Dependent Child, a child for whom the Subscriber's Dependent Child has legal guardianship, a stepchild of the Subscriber's Dependent Child, or foster child of the Subscriber's Dependent Child. These same definitions apply to dependents of the Dependent Child(ren) of the Subscriber's living, covered Spouse; and 2. The Subscriber's Dependent Child must be a Covered Dependent under this Certificate of Insurance for the Dependent of the Dependent Child to be eligible; and The Dependent Child must be chiefly dependent on the Subscriber for support [N.D.C.C. §26.1-36-22 (3)(4)] .
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	An Eligible Dependent includes: (1) The Spouse of the Subscriber; (2) A Dependent child who is related to the Subscriber as a natural child, a child placed for adoption, a legally adopted child, a child for whom the Subscriber has legal guardianship, a stepchild, or a foster child; and is one of the following: (a) under the age of twenty-six (26), (b) incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within thirty-one (31) days of the Plan's request. If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility; and (3) a Dependent of Dependent (a) Is the natural child of the Subscriber's Dependent child, a child placed with the Subscriber's Dependent child for adoption, a legally adopted child by the Subscriber's Dependent child, a child for whom the Subscriber's Dependent child has legal guardianship, a stepchild of the Subscriber's Dependent child, or foster child of the Subscriber's Dependent child. These same definitions apply to dependents of the Dependent child(ren) of the Subscriber's living, covered Spouse; and (b) the Subscriber's Dependent child must be a Covered Dependent under this Certificate of Coverage for the dependent of the Dependent child to be eligible; and (c) The Dependent Child must be chiefly dependent on the Subscriber for support. [N.D.C.C. §26.1-36-22 (3)(4)].
Eligible Group Member	Any Group Member who meets the specific eligibility requirements of NDPERS.

Emergency Care Services	Emergency Care Services means: (1) Within the Service Area: covered health care services rendered by Participating or Non-Participating Providers under unforeseen conditions that require immediate medical attention. Emergency care services within the Service Area include covered health care services from Non-Participating Providers only when delay in receiving care from Participating Providers could reasonably be expected to cause severe jeopardy to the Member'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 the Plan's Service Area.
Emergency Medical Condition	A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any 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.
Encounter	Any type of initiated contact between a member and provider via a qualified telehealth technology platform.
Enrollee	An individual who is covered by this Plan.
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 must be utilized if the Member, or Practitioner and/or Provider acting on behalf of the Member, believes that an expedited determination is warranted.
Experimental or Investigational Services	Health Care Services where the Health Care Service in question either: 1. is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or 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.
Family Coverage	The Class Of Coverage identifying that the Subscriber and Eligible Dependents are enrolled to received benefits for Covered Services under this Plan.
Formulary	A list of prescription medication products, which are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modifications. Additional medications may be added or removed from the Formulary throughout the year.

Gestational Carrier	An adult woman who enters into an agreement to have a fertilized egg, gamete, zygote or embryo implanted in her and bear the resulting child for intended parents, where the embryo is conceived by using the egg and sperm of the intended parents.
Grievance	A written complaint submitted in accordance with the Plan's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the Plan relative to the Member.
[The] Group or [This] Group	NDPERS has signed an agreement with Sanford Health Plan to provide health care benefits for its eligible employees, retirees, and Eligible Dependents.
Group Contract Holder	The individual to whom a Group Contract has been issued.
Group Member	Any employee, sole proprietor, partner, director, officer or Member of the Group.
Health Care Services	Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease.
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. Benefits may not be restricted in a way that is based upon the number of hours that the Member stays in the Hospital.
Iatrogenic Condition	Illness or injury because of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error.
Infertility Services Deductible Amount	A specified dollar amount payable by the Member during their lifetime for infertility services. The Infertility Services Deductible Amount does not apply toward the Out-of-Pocket Maximum Amount.
In-Network Benefit Level	The PPO Plan level of benefits when a Member seeks services from a Participating Practitioner and/or Provider.
Intensive Outpatient Program (IOP)	Provides mental health and/or substance use disorder outpatient treatment services during which a Member remains in the program a minimum of three (3) continuous hours per day and does not remain in the program overnight. Programs may be available in the evenings or weekends.

Intermediate Care	Intermediate Care means care in a Facility, corporation or association licensed or regulated by the State for the accommodation of persons, who, because of incapacitating infirmities, require minimum but continuous care but are not in need of continuous medical 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.
Maintenance Care	Treatment provided to a Member whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Health Care Provider. *Exception: periodic reassessments are not considered Maintenance Care.*
Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for covered services and supplies. Sanford Health Plan's Maximum Allowable Amount is the lesser of (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 Costs for facilities providing the same or similar services, plus a margin factor.
Medically Necessary or Medical Necessity	Health Care Services that are appropriate and necessary as determined by any Participating Provider, in terms or type, frequency, level, setting, and duration, according to the Member's diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must be consistent with generally accepted standards of medical practice as recognized by the Plan, as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and A. help restore or maintain the Members health; or B. prevent deterioration of the Member'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
Member	The Subscriber and, if another Class of Coverage is in force, the Subscriber's Eligible Dependents
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.
NDPERS	the North Dakota Public Employees Retirement System.

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 Members for services related to Never Events.
Non-Covered Services	Those Health Care Services to which a Member is not entitled and are not part of the benefits paid under the terms of This Contract.
Non-Participating Provider	A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.
Non-Payable Health Care Provider	A Health Care Provider that is not reimbursable by the Plan. 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 Member's immediate family.
Open Enrollment or Open Enrollment Period	A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan
Out-of-Network Benefit Level	The Basic Plan level of benefits provided when a Member seeks services from a Non-Participating Practitioner and/or Provider. This is most often referred to as benefits received under the Basic Plan level but may include services received from Practitioners and/or Providers that have not signed a contract with the Plan.
Out-of-Pocket Maximum Amount	The total Deductible and Coinsurance Amounts for certain Covered Services that are a Member'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, less Copayment Amounts incurred during the remainder of the Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period. Medical and prescription drug Copayment amounts do not apply toward the Out-of-Pocket Maximum Amount.
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.
Participating [Health Care] Provider	A Provider who, under a contract with the Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, directly or indirectly, from the Plan. A Participating Provider includes Providers at either the Basic or PPO Plan level.
Physician	An individual licensed to practice medicine or osteopathy.

[The] Plan or [This] Plan	Sanford Health Plan.
Plan Administrator	North Dakota Public Employees Retirement System (NDPERS)
PPO (Preferred Provider Organization) Plan	A group of Health Care Providers who provide discounted services to the Members of NDPERS. Because PPO Health Care Providers charge Sanford Health Plan less for medical care services provided to the Members of NDPERS, cost savings are passed on to Members by way of reduced Cost Sharing Amounts. To receive a higher payment level, Covered Services must be received from an NDPERS PPO Health Care Provider. Health Care Providers accessed at the PPO level are also Participating Providers.
Practitioner	A professional who provides health care services. Practitioners are usually required to be licensed as required by law. Practitioners are also Physicians.
Preauthorization	The process of the Member or the Member's representative notifying Sanford Health Plan to request approval for specified services. Eligibility for benefits for services requiring Preauthorization is contingent upon compliance with the provisions in Sections 2, 4 and 5. Preauthorization does not guarantee payment of benefits.
Prescription Drug Out-of-Pocket Maximum Amount	The total Formulary Out-of-Pocket Amount for Prescription Medications that is a Member's responsibility during a Benefit Period. When this Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications, less Copayment Amounts incurred during the remainder of the Benefit Period. This Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period.
Preventive	Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan.
Primary Care 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 Member.
Prior Approval	The process of the Member or Member's representative providing information to Sanford Health Plan substantiating the medical appropriateness of specified services in order to receive benefits for such service. This information must be submitted in writing from the Member's Health Care Provider. Sanford Health Plan reserves the right to deny benefits if Preauthorization/Prior Approval is not obtained.
Prospective (Pre-service) Review	Means Urgent and non-Urgent Utilization Review conducted prior to an admission or the provision of a Health Care Service or a course of treatment.
[Health Care] Provider	An individual, institution or organization that provides services for Plan Members. 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.
Qualifying Event	A change in your life that can make you eligible for a Special Enrollment Period to enroll in health coverage. Examples of qualifying life events are moving to a new state, certain changes in your income, and changes in your family size (for example, if you marry, divorce, or have a baby) and gaining membership in a federally recognized tribe or status as an Alaska Native Claims Settlement Act (ANCSA) Corporation shareholder.
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
Reduced Payment Level	The lower level of benefits provided by The Plan, as defined in the Summary of Benefits and Coverage, when a Member seeks services from a Participating or Non-Participating Provider without certification or prior-authorization when certification/prior-authorization is required.
Residential Treatment Facility	An inpatient mental health or substance use disorder treatment Facility that provides twenty-four (24) hour availability of qualified medical staff for psychiatric, substance abuse, and other therapeutic and clinically informed services to individuals whose immediate treatment needs require a structured twenty-four (24) hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, substance abuse education/counseling. Facilities must be under the direction of a board-eligible or certified psychiatrist, with appropriate staffing on-site at all times. If the Facility provides services to children and adolescents, it must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children. Hospital licensure is required if the treatment is Hospital-based. The treatment Facility must be licensed by the state in which it operates.
Retrospective (Post-service) Review	Means any review of a request for a benefit that is not a Prospective (Pre-service) Review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication of payment. Retrospective (Post-service) Review will be utilized by Sanford Health Plan to review services that have already been utilized.
Serious Reportable Event	An event that results in a physical or mental impairment that substantially limits one or more major life activities of a Member or a loss of bodily function, if the impairment or loss lasts more than seven (7) days or is still present at the time of discharge from an inpatient health care Facility. Serious events also include loss of a body part and death. Participating Providers are not permitted to bill Members or the Plan for services related to Serious Reportable Events.
[NDPERS] Service Agreement and/or [Group] Contract	The Service Agreement between NDPERS and Sanford Health Plan that is a contract for Health Care Services, which by its terms limits eligibility to enrollees of a specified group. The Group Contract may include coverage for Dependents.
Service Area	The geographic Service Area approved by the State's Insurance Department.

Single Coverage	The Class Of Coverage identifying that only the Subscriber is enrolled to received benefits for Covered Services under this Plan.
Skilled Nursing Facility	A Facility that is operated pursuant to the presiding state law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly-licensed Physician.
Spouse	The Subscriber's spouse, under a legally existing marriage, is eligible for coverage, subject to the eligibility requirements as designated by NDPERS.
[This] State or [The] State	The State of North Dakota.
Subscriber	An Eligible Group Member who is enrolled in the Plan whose employment or other status (except family dependency) is the basis for eligibility for enrollment in the Plan. A Subscriber is also a Member and Enrollee.
Surrogate	An adult woman who enters into an agreement to bear a child conceived through assisted conception for intended parents.
Summary of Benefits and Coverage or SBC	Attachment I of this Contract that sets forth important information on coverage and Cost Sharing.
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: A. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or B. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
Urgent Care Situation	An Urgent Care Situation is a degree of illness or injury, 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. Urgent care 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: A. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or B. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
Us/We/Our	Refers to Sanford Health Plan
Utilization Review	A set of formal techniques used by the Plan to monitor and evaluate the medical necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Prospective (pre-service) Review, second opinion, Preauthorization/Prior Approval, Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review.
You	Refers to the Subscriber or Member, as applicable.

ATTACHMENT I. SUMMARY OF BENEFITS AND COVERAGE

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

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

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

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

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

- Life Insurance
  - o $300,000 in death benefits
  - o $100,000 in cash surrender or withdrawal values

- Health Insurance
  - o $500,000 in hospital, medical and surgical insurance benefits
  - o $300,000 in disability income insurance benefits
  - o $300,000 in long-term care insurance benefits
  - o $100,000 in other types of health insurance benefits

- Annuities
  - o $250,000 in withdrawal and cash values

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

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

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

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

COMPLAINTS AND COMPANY FINANCIAL INFORMATION

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

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

HP-3203 6-19