Sanford Health Plan

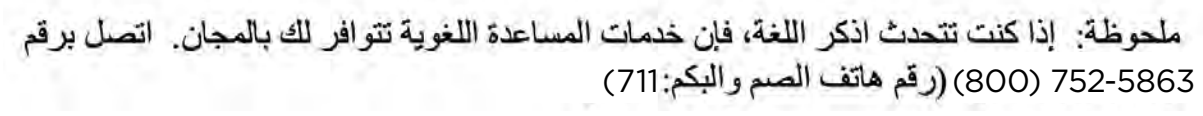
Member Handbook 2024-25

NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM | SANFORD HEALTH PLAN

Help in Other Languages

For help in any language other than English, call (800) 752-5863 (TTY: 711).

Arabic –



Amharic – ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶችማስታወሻ: 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 ကျိာ်အဃိ, 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, ໂດຍບໍ່ເສັ ງຄ່າ, 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 (TTY: 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).

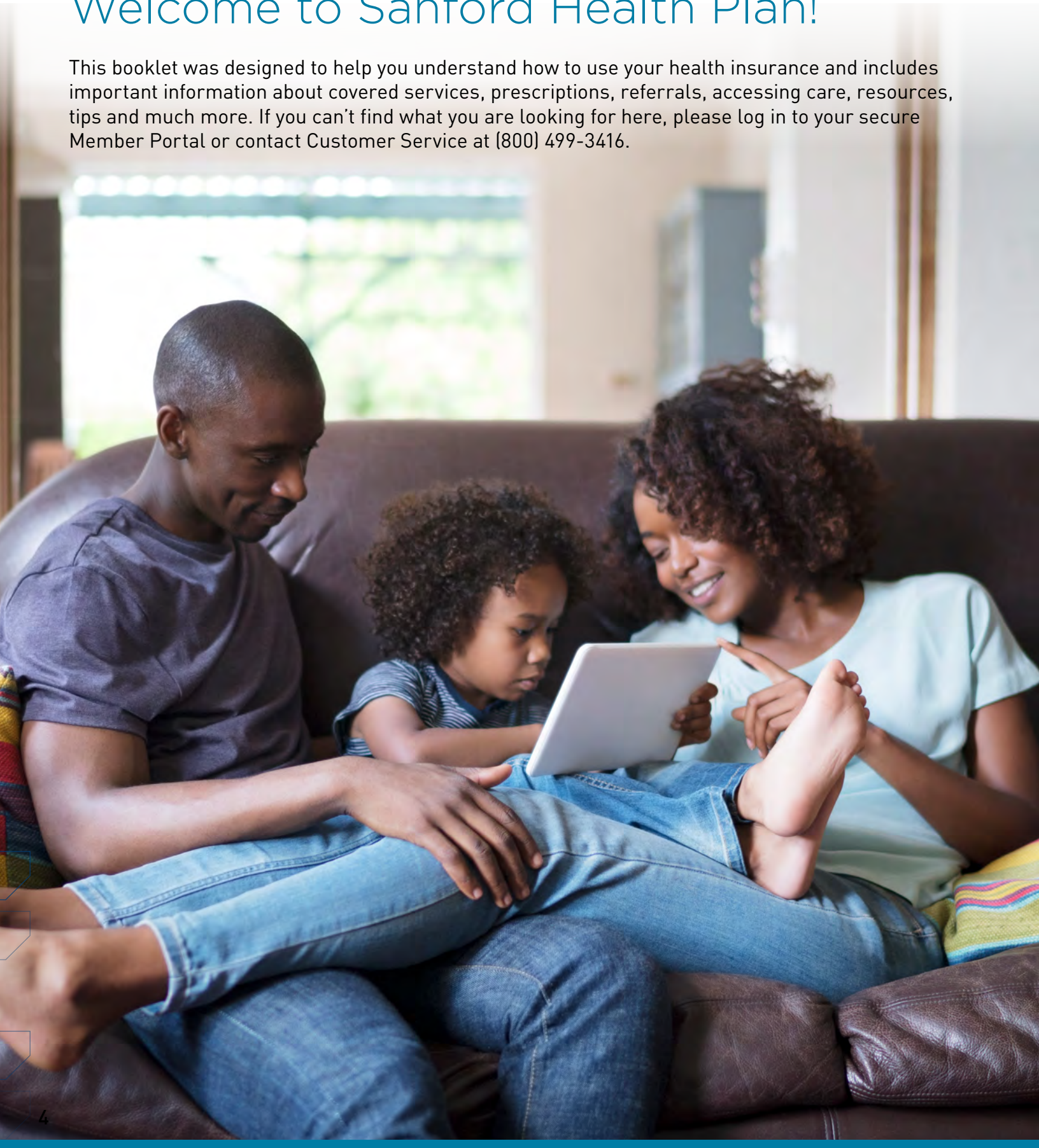
Thai – เรียน: ถ ้าคุณพูดภาษาไทยคุณสามารถใช ้บริการช่วยเหลือทางภาษาได ้ฟรี โทร (800) 752-5863 (TTY: 711).

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).

Table of Contents

Welcome to Sanford Health Plan!

This booklet was designed to help you understand how to use your health insurance and includes important information about covered services, prescriptions, referrals, accessing care, resources, tips and much more. If you can't find what you are looking for here, please log in to your secure Member Portal or contact Customer Service at (800) 499-3416.



Contact Information

Sanford Health Plan is ready to help Monday through Friday, 8 a.m. to 5:00 p.m. CST and a confidential voicemail is available after hours and on weekends. You can also contact us by logging into your Member Portal online at sanfordhealthplan.com or go to **sanfordhealthplan.com/memberlogin**. All calls and emails will be returned within one business day.

Department	Questions about:	Phone Number	Email
Customer Service	Benefit questions, claim inquiries/status, eligibility and enrollment, provider access, complaints, appeals and order ID cards	(800) 499-3416 TTY: 711	memberservices@sanfordhealth.org
Pharmacy Management	Prior approval (authorization) of prescription drug coverages and covered medication list (formulary)	(800) 499-3416	pharmacyservices@sanfordhealth.org
Utilization Management	Prior approval of medical services and utilization review	(888) 315-0885	um@sanfordhealth.org
Care Management	Care management, health management and quality activities	(888) 315-0884	shpcasemanagement@sanfordhealth.org
Vision impaired services	Large print materials or recorded versions of our documents are available upon request.	(800) 499-3416	N/A
Language assistance	Free language assistance is available for those who speak a language other than English.	(800) 499-3416	N/A

Member feedback

Please contact Customer Service or visit sanfordhealthplan.com and click "Share Your Experience" if you would like to provide feedback on how we can continue to improve our service.

Member Rights and Responsibilities

At Sanford Health Plan, we're here to make sure you receive top-notch, personalized healthcare that's easy to access. To show you how much we care, we've put together a list of rights and responsibilities for our members (or the member's parent, legal guardian or other representative if the member is a minor or incompetent). To access your member rights and responsibilities:

- Locate Rights and Responsibilities in your Certificate of Insurance (COI)/Summary Plan Description (SPD)
- Visit **sanfordhealthplan.com/members/important-documents**
- Call our customer service team at (800) 499-3416 (TTY: 711).

Customer Service is available 8 AM to 5 PM CST Monday-Friday
Phone: (800) 499-3416 | TTY: 711
Free translation assistance (800) 752-5863

Coverage Information

You can find specific information about your benefits in the following documents, which are located within your secure Member Portal or by contacting Customer Service.

Summary of Benefits & Coverage (SBC): Deductible and copay information, out of pocket limits, information about covered services, provider network, referral information, pharmacy information and costs.

Covered medication list (formulary): A list of regular and specialty medications that are covered, not covered, require pre-approval or step therapy.

Plan document (Certificate of Insurance): Complete overview and description of all benefits, exclusions, prescriptions, appeals, denials, claims, enrollment, notices, policies and more.

Member Portal

Visit **sanfordhealthplan.com** to sign in or register for 24/7 access to all of your benefit information including:

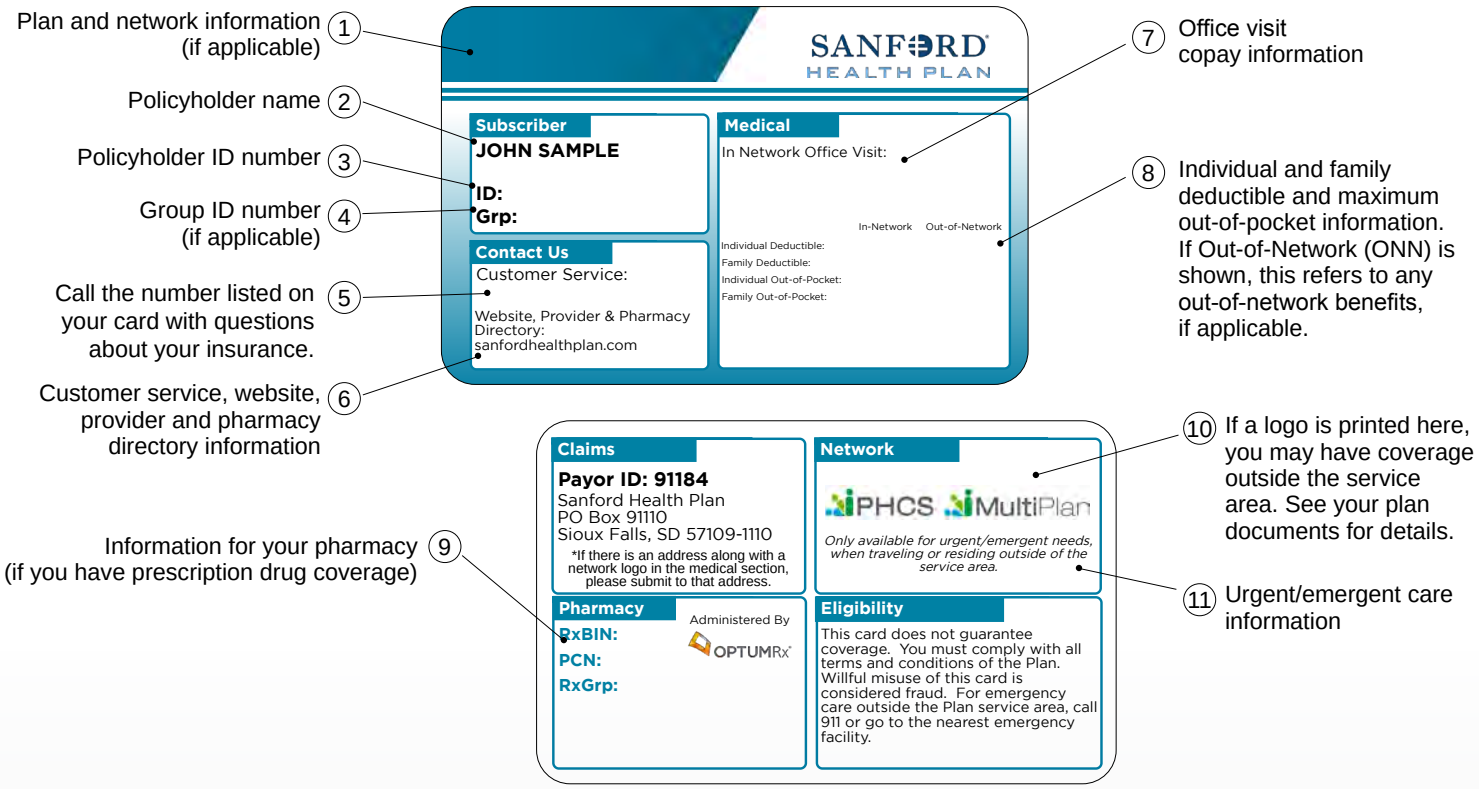
- Summary of Benefits and Coverage (SBC)
- Plan document (policy)
- Pharmacy benefit information
- Claims and explanation of benefits (EOB)
- Preventive care
- Specialty programs
- Provider and pharmacy directory
- Referral information
- Wellness Portal
- Health insurance forms
- Federal and state guidelines and notices

Any dependent, such as a child or spouse, on your plan over age 18 requires a separate Member Portal due to privacy law. Complete the consent form, located in the Member Portal to provide separate access.

Member ID Card

Your Member ID card should be used at each provider visit or when filling a prescription. An explanation of the important information shown on your card is below for your reference. Member ID cards should be received before the policy is activated. If you have not received your ID card or you've lost your ID card and need medical care, log in to the Member Portal to view or print a temporary card or request a new one. A provider can also contact Sanford Health Plan to verify your insurance coverage.

- If you need to fill a prescription and do not have your ID card, you will have to pay for the medication and submit a paper claim to the plan for reimbursement.



** Actual ID Card for your plan may vary.*

Customer Service is available 8 AM to 5 PM CST Monday-Friday
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Free translation assistance (800) 752-5863

Navigating Your Network

Sanford Health Plan NDPERS Members have access to a Preferred Provider Organization (PPO) and Basic Network.

How much you pay for care will depend on your choice of provider; those contracted with Sanford Health Plan will be paid at the PPO level and those not directly contracted will be paid at the Basic Plan level.

If a PPO provider is not available in your area, you decide to travel outside of the service area for care without pre-approval from the plan, or you see a non-PPO provider, claims will be processed under the Basic Plan level benefits. For more information, refer to your Policy Document.

To find a participating provider or pharmacy, visit sanfordhealthplan.com or log in to your Member Portal at sanfordhealthplan.com/memberlogin. Customer Service is available to help if you'd like more information about a provider or assistance finding a PPO provider or pharmacy.

Participating and Non-Participating Providers

When you receive health care services from a Participating Provider, they will send all necessary information to Sanford Health Plan to process claims per your plan benefits. You will be responsible for any applicable cost sharing (copay, deductible and/or coinsurance) or services that may not be covered by your plan.

If you receive health care services from a Non-Participating Provider that is not directly contracted with Sanford Health Plan, we may ask for additional information to ensure claims for your care process per your plan benefits. We will contact you if assistance or additional information may be needed.

The Plan allows you the flexibility to choose your own providers, including in-network specialists without a referral, however, choosing to receive covered services from a PPO provider helps Members save on out-of-pocket costs as the Plan is able to receive a greater discount on healthcare services when a contract is in place. Refer to the Referrals and Pre-approval section for more information on the prior authorization process.

Our Provider Directory can be found at **sanfordhealthplan.com/findadoctor**. This directory includes in-network and participating providers information as well as the following:

- Name
- Address
- Telephone numbers
- Gender
- Website
- Specialty/Professional qualifications
- Languages spoken
- Accepting new patients
- Hospital affiliation
- Medical group affiliation
- Board certification
- Last credentialed date
- Has taken cultural competence training

Please contact us if you would like more information on medical school or residency information.

Care Options

You have multiple choices regarding when and where you receive care. Choosing the appropriate care setting helps you to maximize your health insurance benefits and save on out-of-pocket costs.

Routine office visit

Your primary care provider (PCP) is best for routine, preventive or visits that could wait 24 to 48 hours or longer. If same day care is needed, your PCP may be able to see you or the clinic may be able to help you find another available provider. If you need behavioral health care, you are covered at the same cost as your other benefits under your plan.

Experimental and investigational procedures or services are not covered; however, you may request a review of a denied request through the appeal process. Your request will be considered by the plan based on our medical policy guidelines.

Urgent (acute) care

An urgent care situation is not a serious health threat, but requires medical attention within 24 hours, and may include stitches, pain, urinary tract or respiratory infections, fever, or flu.

During the day:

First, contact your primary care provider:

- If your provider is unable to see you that day, ask if another provider in the clinic may be available

After hours, on weekends or holidays:

- Visit a participating urgent care clinic (check the Provider Directory for options)

Specialty care

If you need to see a specialist, you do not need a referral from the Health Plan, however the provider may require one to schedule an appointment.

Behavioral healthcare services

If you need assistance locating Behavioral Healthcare Services, please call our Care Management department at (888) 315-0884.

Emergency care

Emergency medical conditions require immediate care to avoid serious harm. Emergent conditions may include severe pain, suspected heart attack or stroke, difficulty breathing, bleeding that won't stop, severe burns, seizures, poisoning, or trauma. For emergency care, call 911 or visit the nearest emergency department. If you receive care in an emergency situation:

- Pre-approval is not necessary in a true emergency situation.

Hospital services

If you require elective or emergent inpatient (hospital) services, please notify us as soon as possible.

Emergency transportation

Ground transportation, air ambulance or a commercial flight will be covered per your plan if deemed medically necessary.

Care when traveling

Care outside of the service area will be covered per your plan in emergent situations. If you need emergent care while traveling, please contact Sanford Health Plan within 48 hours of seeking care. Treatment facilities outside the United States may not bill your insurance and may require you to pay in full for services. If this occurs, save your receipts, and ask for a detailed list of charges in English. Submit a paper claim, and we will reimburse you for covered services.

If traveling outside the U.S., look up the local emergency number, as it may not be 911.

On-demand health services

- **Nurse Line:** This free resource is available to address medical questions and get medical advice. Call (888) 315-0886 to visit with a Registered Nurse or log in to your Member Portal to send a secure message. If you contact us through the portal, you will receive a response within 1 business day.

Pharmacy and Medication Benefits

The Sanford Health Plan Pharmacy Department will help you get the most out of your medication benefits. A brief explanation of your benefits is described below; for full details on your medication coverage, participating pharmacies and more, log in to your secure Member Portal.

Drugs that are not considered medically necessary (such as cosmetic medications) are excluded from coverage. Check your Formulary or plan documents for details on covered and excluded medications.

Sanford Health Plan has a list (formulary) of FDA approved brand name and generic medications that are covered under your benefit plan. Selection criteria for medications on the list include effectiveness, safety and cost. Changes are made throughout the year as necessary, with a complete review performed each year.

By following the formulary and asking your provider for generic medications when available, you will save money and help control the costs of your health care. Refer to your Summary of Benefits and Coverage (SBC) for information on medication costs under your plan. If you request a brand name medication when there is an equivalent generic or biosimilar alternative available, you will be required to pay the price difference between the brand and the generic or biosimilar product, in addition to your copay (with the traditional copay plan).

For medications to be covered, they must be:

1. Prescribed or approved by a physician, physician assistant, nurse practitioner or dentist;
2. Listed in the plan formulary, unless pre-approval (authorization) is given by the plan;
3. Provided by a participating pharmacy except in the event of a medical emergency;
   NOTE: If a prescription is filled at a non-participating and pharmacy, you will be responsible for the prescription drug cost in full.
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

Additional medication information

- With certain medications, you must first try lower cost and/or generic versions before higher cost alternatives will be covered. This is called "step therapy". If the first step medication does not work, you have side effects, or your situation falls into one of the other step therapy exceptions, the next step may be tried.
- For safety reasons, some medications (such as pain medications and psychotherapeutic drugs) have quantity limits, meaning only so much medication can be provided over a certain time period. Check the formulary to see which medications have a quality limit (labeled as "QL").
- Like some services, certain medications must also be pre-approved (preauthorized). To receive pre-approval, the prescribing provider must submit a letter of medical necessity and supporting medical information. Refer to your formulary to determine which medications require pre-approval (labeled as "PA").
- Any medications administered in a provider's office, such as injections or infusions, will apply to your medical benefit (deductible/coinsurance may apply based on your plan). If a medication you need is not on the formulary, you or your provider can request an exception. Complete the Formulary Exception Form (available at sanfordhealthplan.com) and return to the Pharmacy Management Department for consideration.
- Interested in signing up for mail order delivery of your prescriptions? Call (866) 833-3463 for information or to sign up.
- The Affordable Care Act (ACA) requires certain medications be provided at no charge if the Member meets certain criteria, if prescribed by a provider and filled at a participating pharmacy. Please reference the table below for additional details or contact us for more information.

No Cost Medications	Details/Dose	Criteria
Aspirin	Over the counter generic (with prescription), dose less than or equal to 81 mg	
Bowel Prep Agents	Select generic prescription for colonoscopy preparation	2 prescriptions per 365 days
Breast Cancer Prevention	Generic risk-reducing medications	Adults greater than or equal to 35 years old
Cholesterol Lowering Medications	Generic statin prescriptions	Adults age 40 to 75, presence of one or more cardiovascular risk factor, no presence of cardiovascular disease
Contraceptives (Birth Control)	Generic and select brand-name birth control products	
Fluoride	Select generic prescriptions and over the counter options	6 months through 5 years of age
Folic Acid	Over the counter products (with prescription), 0.4-0.8 mg	
HIV Preventive Medication	Truvada, generic tenofovir, Discovy	Prior Authorization confirming using for PrEP therapy
Tobacco Cessation Medications	All generic and over the counter medication options	Adults 18 and older, 180-day supply within 365 days

ACA benefits apply only to non-grandfathered plans.

A complete list of in-network pharmacies and all other pharmacy related benefit information can be found in the Member Portal or by contacting Customer Service.

Referrals, Pre-approvals and Other Insurance Coverage

Medical referrals

Sanford Health Plan does not require a referral to see a PPO specialty care provider, but some clinics may still require a referral for you to make an appointment. If you need help finding a provider, refer to the provider directory or contact Customer Service. Remember, some services may be excluded, even if your doctor recommends them, such as acupuncture and cosmetic procedures. See your plan document for additional details on non-covered services.

Pre-approval (preauthorization or precertification) of services

You **must** contact Sanford Health Plan to get pre-approval for select outpatient and all inpatient procedures or admissions. Pre-approval is also needed for dental anesthesia, specialty medications, home health care, select medical equipment, cancer services and treatment, genetic testing and transplants. Please **contact us at least three days before the requested service** to ensure timely processing of your request. A complete list of services requiring pre-approval is available in your plan document, the Member Portal or by contacting Customer Service.

New technology, treatment and clinical trial prior authorization. We are dedicated to the work of health and healing and have a process for consideration of benefit coverage for specific new medical services or products. As a collaborating partner in the health care industry, our internal process of review includes factors such as medical impact, safety, efficacy, clinical trial phase and cost-to-benefit ratios. Our goal is to deliver a timely and thorough determination in that process.

Motor vehicle accidents and on-the-job injuries

If you need medical care and another person or company is responsible, please contact us. We have partnered with Optum, a company who helps us handle claims that could be someone else's responsibility. If you receive a call or form in the mail from Optum, please respond within 10 days or your claims may be denied. You can reach Optum by phone (800) 529-0577 or complete the form online at *icc.optum.com*.

If you have other health insurance (coordination of benefits)

If you are covered by another insurance policy or are eligible for Medicaid or Medicare, we will work with the other insurance company to coordinate benefits to ensure claims are processed in a timely manner. Please complete any forms you receive or contact us, if requested, to ensure your claims are not denied.

Wellness

Sanford Health Plan believes that health goes beyond exercise and nutrition. Considering the whole self leads to a healthier life where you can thrive. Our dimensions of well-being provide you with a framework to examine your health. We have provided suggestions below on how you can improve your well-being in each dimension.

Physical well-being
Aim for 30 minutes of physical activity each day.

Sleep for seven to nine hours each night.

Plan meals ahead of time to avoid making unhealthy decisions about food.

Career well-being
Utilize your strengths every day at work or through volunteering.

Have a best friend at work.

Social well-being
Spend intentional time each day socializing with a friend or family member.

Work on having more positive interactions during your day than negative ones.

Financial well-being
Buy experiences such as vacations and outings with friends and loved ones.

Set up defaults like automatic bill pay and transfers to savings to reduce your financial worries.

Emotional well-being
Strive for progress, not perfection.
Be kind to yourself.

Set aside at least five minutes a day to reflect. Spend this time journaling, expressing gratitude or thinking in silence.

Control what you can control (your reaction), and let the rest go.

Community well-being
Practice informal volunteering by helping out a friend, family member or neighbor each day.

Think outside of the box, and give back as a special way to celebrate a birthday, anniversary or other occasion.

Talk with friends, family and co-workers about your interest in giving back to find new volunteering opportunities.

Wellness Portal

Within your secure Member Portal, you also have access to a Wellness Portal powered by WebMD, which contains a variety of wellness resources, recipes, and more. After completing a health assessment, the Portal becomes personalized to support your personal health and wellness goals.

Dakota Wellness Program

Each year, NDPERS employees and spouses covered by Sanford Health Plan can earn a $250 ($500 per household) wellness benefit by practicing healthy habits.

Step 1: Take your annual health assessment

Log into your account at sanfordhealthplan.com/memberlogin. (Forgot username and password options are available, if necessary.) If you do not have an account, select the "Request Access for Yourself" button. Click on Menu and under the Insurance header, click Portals and Links, then select Wellness Portal to complete your yearly assessment.

Step 2: Engage in health and wellness activities

Earn your $250 wellness benefit by:

- Going to the gym.
- Attending work site wellness events. Be sure to complete and return the Dakota Wellness Program Voucher for credit toward your Wellness Benefit.
- Earning points in the online wellness portal.

For detailed information on how the Dakota Wellness Program works and how to earn your yearly benefit, go to sanfordhealthplan.com/ndpers/dakotawellnessprogram.

Fitness center reimbursements

Sanford Health Plan will pay up to $20 per Member per month when you use your home fitness center 12 days per month. To sign up, go to **NIHCArewards.org** to enroll online. Under "Member Options", click "First Time Enrollment" and select Sanford Health Plan from the drop down menu. Select your home fitness center location click "Enroll Online." Read and agree to the terms of service, and enter your contact, health plan and banking information and click "Submit."

If you visit your home fitness center at least 12 times per month, most participants receive an automatic deposit into a bank account around the 21st of each month. If your fees are less than $20 per month, the credit will reflect the amount you pay each month. You can view the status of your reimbursements in your NIHCA Member account at **NIHCArewards.org**. Please contact your fitness center directly if you find any errors regarding reimbursement. For other errors, please contact Sanford Health Plan at (800) 499-3416 for assistance. Please note, it is the Member's responsibility to ensure your gym visits are recorded and payments are received.

If you end your fitness center membership or become delinquent in your membership dues, you will not be eligible for reimbursement. If you move your gym membership to a new facility, log on to **NIHCArewards.org** and select your new gym to continue receiving reimbursements.

Customer Service is available 8 AM to 5 PM CST Monday-Friday
Phone: (800) 499-3416 | TTY: 711
Free translation assistance (800) 752-5863

Healthy Pregnancy Program

If your family is expecting, NDPERS and Sanford Health Plan want to make sure you have the tools and support you need to give your baby the healthiest start possible. This free program offers over $850 in savings and additional benefits, including:

- Deductible waiver (for women who participate in a Grandfathered/Non-Grandfathered PPO/ Basic Plan and deliver with a participating provider)
- Free prenatal vitamins
- Support from a care management nurse
- Educational information on pregnancy, childbirth and postpartum
- A baby gift from Sanford Health Plan

You can also access Text4baby to help remind you of doctor visits, personalized tips on prenatal care, baby's growth, signs of labor, nursing, eating habits and more. Text BABY (or BEBE) to 511411 to sign up.

To sign up for the Healthy Pregnancy Program, contact us between your 8th and 34th week of pregnancy at **(888) 315-0884** or visit **sanfordhealthplan.com/ndpers**.

Advance Care Planning

Advance care planning is the process of planning and deciding your future health care in case you are suddenly unable to make your own decisions because of illness or injury. Advance care planning allows you to:

- Think about and discuss treatment options with your family and health care providers to make treatment decisions based on your goals, values and preferences.
- Document and communicate your decisions to those who need to know.
- Select someone you trust to make decisions on your behalf when you are unable to speak for yourself.

Sanford Health Plan encourages all Members to complete an advance directive. A copy should be provided to the person responsible for making decisions in case you cannot speak for yourself, the hospital where you are most likely to receive treatment and your primary provider. For access to free advance care planning resources and documents, go to **sanfordhealth.org**, keywords: '*advance care planning*'.

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Making Changes to Your Plan

After the open enrollment period, you may be able to enroll in health insurance if you experience a life-changing event, such as job status changes, a change in residence for yourself and/or your dependents, you get married or divorced, have or adopt a child, or become eligible for state premium assistance. This is known as a special enrollment period; see your plan document for full details.

Additionally, if you declined enrollment for yourself or your dependents (children or spouse) because you had other health insurance, including state or federal coverage, you or your dependents may be eligible to enroll in your plan if eligibility for the other coverage is lost.

To enroll or remove dependents outside of open enrollment, contact your employer:

- 31 days after a life changing event or other group health plan coverage ends
- 60 days after the date of eligibility for state premium assistance is determined or terminated

If we request additional information, it must be returned within 30 days. Additionally, verification may be required for any dependent covered on your policy who is disabled or over age 26.

Claims and Payment of Services

After you receive medical care, most providers will file a claim for you. However, you may need to file a claim if your provider did not file one for you. Claim forms can be found in the Member Portal or by contacting Customer Service. A copy of an itemized statement (breakdown of charges) from your provider and proof of payment will be needed to process the claim.

After your claim is received and processed according to your benefits, Sanford Health Plan will send payment to the provider, and an Explanation of Benefits (EOB) to you.

All claims must be received within 180 days from the date of service or within 365 with a national network provider. If your claim is not received within the allotted time, you may be responsible for all costs.

Explanation of benefits

After you receive health care services and we process the claim, you will receive an explanation of benefits (EOB) that explains how your insurance benefits were applied. A claim for services is typically received and processed within 30 days. If you've signed up to receive electronic EOBs, you will receive email notification stating that a new EOB is available to view in the Member Portal. If you have not signed up for electronic EOBs, you will receive a paper EOB in the mail. The EOB will provide specific information about all services/claims from th last 30 days.
The EOB is NOT a bill or invoice.

To ensure benefits are applied correctly, wait until you receive your EOBs before paying medical bills.

Complaints

To file a complaint, contact Sanford Health Plan through the Member Portal, by phone or by mail at Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.

Appeals

You have a right to appeal any decision made by Sanford Health Plan to not pay for an item or service. To file an appeal, complete an Appeal Form in the Member Portal, or contact Customer Service to file an appeal over the phone or to have a form mailed to you.

Customer Service is available 8 AM to 5 PM CST Monday-Friday
Phone: (800) 499-3416 | TTY: 711
Free translation assistance (800) 752-5863

How to Read Your Explanation of Benefits (EOB)

Sanford Health Plan wants to help you understand your health care coverage. An Explanation of Benefits (EOB) is not a bill; it explains how your benefits have been applied. It also shows what Sanford Health Plan paid for your care and what amount you may be responsible for. Review your EOB carefully along with any bills you receive to make sure both statements match.

B Claim Number: 1234567

D Provider/Vendor Name: DOCTOR NAME /FACILITY NAME/PLACE OF SERVICE

A Date of Service	Medical Service Details		Member Benefit		Amount Provider May Bill You				**L** Notes*
	C Type of Service	**E** Amount Billed	**F** Plan Discount	**G** Amount Paid by Plan	**H** Copay	**I** Deductible	**J** Coinsurance	**K** Amount Not Covered	
XX/XX/XXXX – XX/XX/XXXX	<type of service>	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	$XX.XX	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	<claim notes>
	Claim Total:	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	$XX.XX	$XXXXX.XX	$XXXXX.XX	$XXXXX.XX	
						Amount You May Owe		$XXXXX.XX	

L

*Notes
<claim notes>

A **Date of Service:** The date(s) you received care.

B **Claim Number:** Reference number Sanford Health Plan assigned to the submitted claim.

C **Type of Service:** Type of medical service received.

D **Provider/Vendor Name:** The provider or facility you received the service from.

E **Amount Billed:** Amount the provider or facility billed for the service.

F **Plan Discount:** Amount saved by using an in-network or participating provider (if applicable). Sanford Health Plan negotiates lower rates with these providers to help save money.

G **Amount Paid by Plan:** The maximum amount Sanford Health Plan allows a provider or facility to charge for the service(s).

H **Copay:** A set amount you pay for certain services, such as an office visit.

I **Deductible:** The amount of covered expense that must be paid by the member before Sanford Health Plan begins to pay. For example, if your deductible is $1,500, Sanford Health Plan won't pay for covered benefits until you've paid $1,500 for services that are subject to the deductible, which may include labs, imaging, procedures and hospitalizations.

J **Coinsurance:** The percentage of the payment that you are responsible for, once the deductible has been met. Coinsurance amount is calculated on the amount paid by the plan. For example, if you have a $100.00 service after you've met your deductible and your coinsurance is 80/20, the Plan will pay for 80 percent ($80) and you will pay 20 percent ($20).

K **Amount Not Covered:** Any amount that may not be covered by your benefit plan.

L **Notes:** Important information; these numbers and/or codes explain more about how claim was processed.

Saving Money on Your Healthcare

Even if you have insurance, there are additional ways you can save time and money on health care, and Sanford Health Plan wants to help. Follow the tips below to help keep your health care affordable.

Live a healthy lifestyle. Choosing to eat well, exercise regularly, lose weight or quit smoking (if needed) and getting enough sleep will help you feel good and stay healthy. If you have been diagnosed with a medical condition, take prescribed medications and follow up as directed to keep your condition well controlled.

Choose the plan that's right for you. Health insurance is not one size fits all. Take some time to research your options and pick the plan that's right for you and your family. This simple step can help you maximize your benefits and save you money in the long run.

Know your coverage. Review the specifics of your policy each year so you know what to expect when using your benefits.

Use your preventive care benefits. Sanford Health Plan offers free preventive health care services to help you stay healthy. Regular physicals, screenings and immunizations can help detect medical problems early. The Member Portal also offers a Wellness Portal to help you stay healthy.

Use a PPO provider. Using PPO providers and facilities will help you pay less for services and prescriptions.

Choose the right setting for care. Avoid the emergency room if urgent care or a visit with your primary doctor will address your problem.

Use generic prescription drugs. Generic drugs are FDA approved and as safe and effective as name brand medications. Generics contain the same active ingredients, which means they work the same and cost much less.

Take advantage of special programs. Sanford Health Plan offers case management programs for those with complex medical or behavioral health needs, undergoing treatment for kidney disease, cancer, high risk pregnancy, transplant or are transitioning from hospital to home.

Pay your bill early. If you receive care at Sanford Health, you can save 10 percent if you pay your bill within 30 days.

Glossary of Terms

Allowed Amount: Shown on the explanation of benefits (EOB), this is the maximum amount the plan pays a provider for a covered service. Even with the same service, the allowed amount may be different for in-network versus national network providers.

Ancillary Service: Supplemental healthcare services such as laboratory work, x-rays or physical therapy that are provided in conjunction with medical or hospital care. Ancillary fees may also be associated with obtaining prescription drugs that are not on the formulary (covered medication list).

Basic Plan Benefits: Care received from a facility, provider or supplier that is not a part of the Preferred Provider Organization (PPO). Benefit payment will be paid per the Basic Plan Benefit level as specified in the plan documents.

Claim: The document sent to the plan from your provider showing the services or products provided to you.

Coinsurance: The percentage of costs for covered services you are responsible for after you meet your deductible. Coinsurance is based on the allowed amount for the service. If you've met your deductible and your coinsurance is 20 percent, the plan will pay 80 percent of the allowed amount for a service and you pay 20 percent. For example, if you've met your deductible and the allowed amount for a service is $100, the plan would pay $80 and you would be responsible for $20.

Copay or copayment: The dollar amount you pay each time you visit the doctor or fill a prescription. For example, if your office visit copay is $20, you would pay this amount and the plan would cover the rest of the allowed amount. Depending on your plan, you may or may not have a copay option for certain services. Copays do not apply to your deductible, but they do apply to your out of pocket expenses.

Deductible: The cost of covered services you pay at 100 percent before Sanford Health Plan begins to pay. For example, if your deductible is $1,500, the plan won't pay until you've met your $1,500 deductible for certain services, such as labs, imaging, procedures and hospitalizations.

Excluded (non-covered) services: Sanford Health Plan does not allow coverage for certain services or products. Charges incurred from non-covered services do not apply to your deductible and/or coinsurance. Please review your plan document for specific information on non-covered services.

Experimental and/or investigational services or procedures: A drug, device, medical treatment, diagnostic procedure, technology, or procedure has not been proven as effective or there are concerns relating to safety, effectiveness, effect on health outcomes or requires governmental approval which has not been granted.

Formulary: A list of medications covered by the plan, which may be updated throughout the year.

Medically necessary: Health care services or supplies needed to prevent, diagnose or treat an illness, injury, condition, disease or its symptoms that meet accepted standards of medicine.

Out-of-network (non-participating) provider: A health care provider not contracted with Sanford Health Plan. There is no discount for services, so you will pay more (or all) for medical services.

Out-of-pocket maximum (limit): The maximum cost to you in a calendar year for covered medical expenses before your insurance plan begins to pay 100 percent.

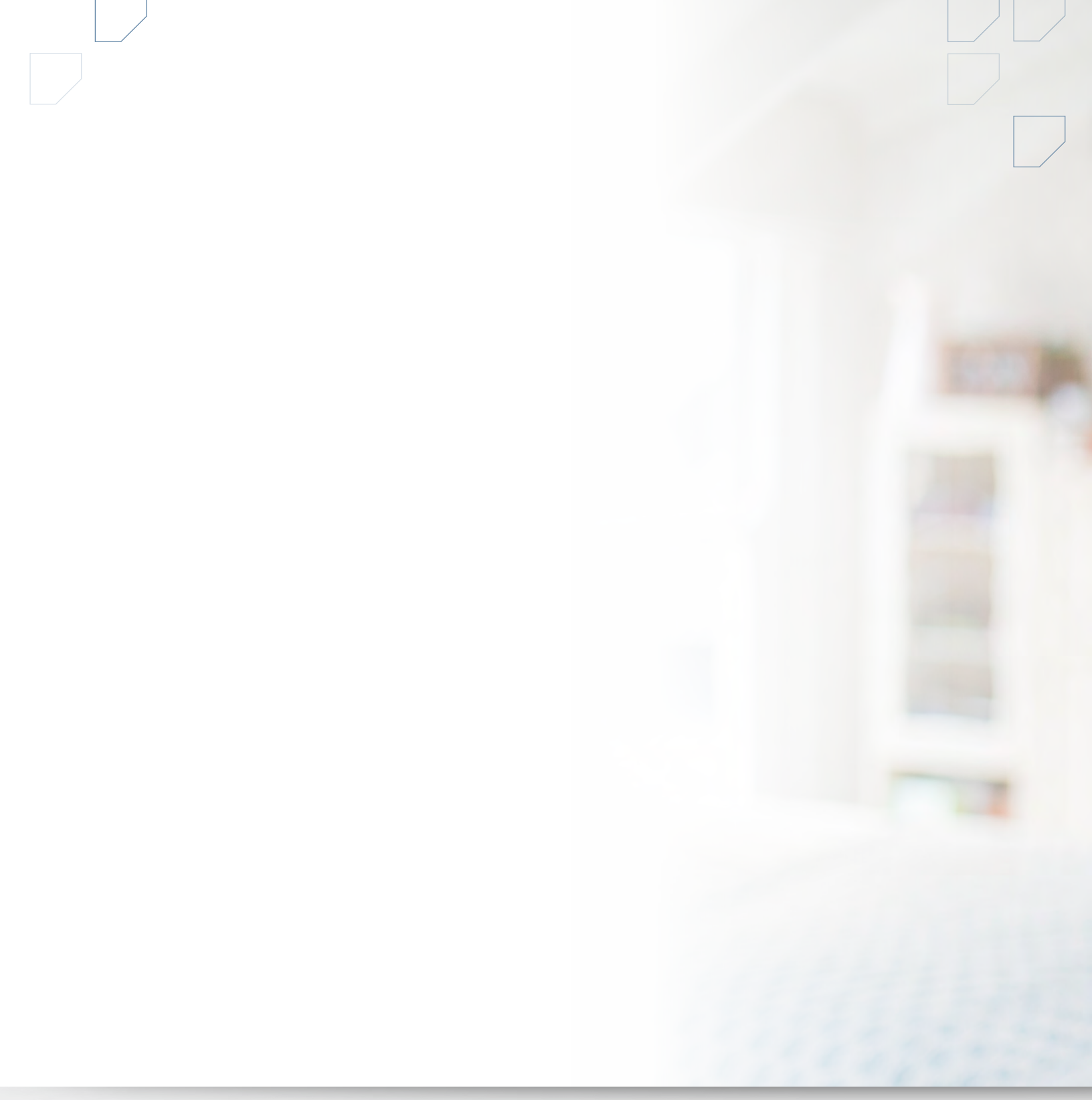
PPO Provider: Participating facilities, providers and suppliers who provide discounted services to the Members of NDPERS. PPO providers charge the Plan less for care and savings are passed on to Members in the form of less out of pocket cost(s).

Pre-approval (preauthorization or precertification): A request that must be submitted for approval of certain services including procedures, hospitalizations and medications before the services are received (except in an emergency). Sanford Health Plan will review the request to determine if it is medically necessary. Prior authorization does not guarantee the plan will cover the cost.

Preferred (in-network) provider: A provider contracted with Sanford Health Plan that allows you to receive health services at a discounted rate. You can save money by using in-network providers.

Premium: The amount you pay on a monthly basis for your health insurance coverage. This amount does not apply toward your deductible and/or coinsurance.

Utilization review: A process which compares requests for medical services (utilization) to recommended treatment guidelines. Also confirms requested services are appropriate and medically necessary.



NORTH DAKOTA
PUBLIC EMPLOYEES
RETIREMENT SYSTEM

SANFORD
HEALTH PLAN

616-925-625 Rev. 10/24 NPP-NPR-NPS