



# Sanford Health Plan

*Iowa*

Large and Small Group  
Certificate of Coverage

PO Box 91110 • Sioux Falls, SD 57109-1110  
(605) 328-6800 • 1-800-752-5663



**SANFORD HEALTH PLAN  
NOTICE OF PRIVACY PRACTICES**

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

The terms of this Notice of Privacy Practices apply to Sanford Health Plan operating as an affiliated covered entity with Sanford Health Plan and Sanford Health Plan of Minnesota. The organization will share personal health information of members as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our members' personal health information and to provide members with notice of our legal duties and privacy practices with respect to your personal health information. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. Copies of revised notices will be mailed to all members then covered by the plan and copies may be obtained by mailing a request to Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110.

**USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION**

**Your Authorization.** Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

**Disclosures for Treatment.** We will make disclosures of your personal health information as necessary for your treatment. For instance, a doctor or health facility involved in your care may request certain of your personal health information that we hold in order to make decisions about your care.

**Uses and Disclosures for Payment.** We will make uses and disclosures of your personal health information as necessary for payment purposes. For instance, we may use information regarding your medical procedures and treatment to process and pay claims, to determine whether services are medically necessary or to otherwise pre-authorize or certify services as covered under your health benefits plan. We may also forward such information to another health plan which may also have an obligation to process and pay claims on your behalf.

**Uses and Disclosures for Health Care Operations.** We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations which include credentialing health care providers, peer review, business management, accreditation and licensing, utilization review and management, quality improvement and assurance, enrollment, underwriting, reinsurance, compliance, auditing, rating, and other functions related to your health benefits plan. We may also disclose your personal health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

**Family and Friends Involved In Your Care.** With your approval, we may from time to time disclose your personal health information to designated family, friends, and others who are

involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval. If you have designated a person to receive information regarding payment of the premium on your Medicare supplement policy, we will inform that person when your premium has not been paid. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

**Business Associates.** Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, actuarial services, legal services, etc. At times it may be necessary for us to provide certain of your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

**Communications With You.** We may communicate with you regarding your claims, premiums, or other things connected with your health plan. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish messages to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. In considering reasonable requests, Sanford Health Plan may consider if disclosure of all or part of the information would endanger the member. You may request such confidential communication in writing and may send your request to Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110.

**Other Health-Related Products or Services.** We may, from time to time, use your personal health information to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products or services which may be available to you as a member of the health plan. For example, we may use your personal health information to identify whether you have a particular illness, and contact you to advise you that a disease management program to help you manage your illness better is available to you as a health plan member. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

**Information Received Pre-enrollment.** We may request and receive from you and your health care providers personal health information prior to your enrollment in the health plan or issuance of a policy. We will use this information to determine whether you are eligible to enroll in the health plan or for a policy, and to determine your rates. We will protect the confidentiality of that information in the same manner as all other personal health information we maintain and, if you do not enroll in the health plan or if the policy is not issued, we will not use or disclose the information about you we obtained for any other purpose.

**Research.** In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a research organization may wish to compare outcomes of patients by payer source and will need to review a series of records that we hold. In all cases where your specific authorization has not been obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or privacy board which oversees the research or by representations of the researchers that limit their use and disclosure of member information.

**Other Uses and Disclosures.** We are permitted or required by law to make certain other uses and disclosures of your personal health information without your authorization. We may release your personal health information for any purpose required by law;

- We may release your personal health information for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- We may release your personal health information as required by law if we suspect child abuse or neglect; we may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- We may release your personal health information to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- We may release your personal health information to your plan sponsor; provided, however, your plan sponsor must certify that the information provided will be maintained in a confidential manner and not used for employment related decisions or for other employee benefit determinations or in any other manner not permitted by law.
- We may release your personal health information if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- We may release your personal health information if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
- We may release your personal health information to law enforcement officials as required by law to report wounds and injuries and crimes;
- We may release your personal health information to coroners and/or funeral directors consistent with law;
- We may release your personal health information if necessary to arrange an organ or tissue donation from you or a transplant for you;
- We may release your personal health information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- We may release your personal health information if you are a member of the military as required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities; and
- We may release your personal health information to workers' compensation agencies if necessary for your workers' compensation benefit determination.

## **RIGHTS THAT YOU HAVE**

**Access to Your Personal Health Information.** You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. You may obtain an access request form from Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110.

**Amendments to Your Personal Health Information.** You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an

amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110.

**Accounting for Disclosures of Your Personal Health Information.** You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110.

**Restrictions on Use and Disclosure of Your Personal Health Information.** You have the right to request restrictions on certain of our uses and disclosures of your personal health information for treatment, payment, or health care operations by notifying us of your request for a restriction in writing. A restriction request form can be obtained from Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction to sending such termination notice to Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110.

**Complaints.** If you believe your privacy rights have been violated, you can file a written complaint with Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110 or you can file a verbal complaint by calling Sanford Health Plan, Member Services Department at (605) 328-6800 or toll free at 1-800-752-5863. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

#### **FOR FURTHER INFORMATION**

If you have questions or need further assistance regarding this Notice, you may contact Sanford Health Plan, Member Services Department at (605) 328-6800 or toll free at 1-800-752-5863. As a member you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means.

#### **EFFECTIVE DATE**

This Notice of Privacy Practices is effective April 14, 2003.

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## Part I - - Definitions

The following terms shall have the following meanings when used in this document:

**“Ambulatory Surgical Center”** means a lawfully operated, public or private establishment that:

- a. Has an organized staff of Practitioners;
- b. Has permanent facilities that are equipped and operated mostly for performing surgery;
- c. Has continuous Practitioner’s services and Nursing Services when a patient is in the facility; and
- d. Does not have services for an overnight stay.

**“Calendar Year”** means a period of one year which starts on January 1st and ends December 31st.

**“Chemotherapy”** means prescription drugs for cancer treatment and Medically Necessary services associated with the administration of the drug.

**“Coinsurance”** means the percentage of charges to be paid by a Member for Covered Services at the time such services are rendered. A Member may be required to pay either a Copay or Coinsurance at the time services are rendered, but will not be required to pay both.

**“Copay”** means an amount that a Member must pay at the time the Member receives a Covered Service which is not fully prepaid. A Member may be required to pay either a Copay or Coinsurance at the time services are rendered, but will not be required to pay both.

**“Covered Services”** mean those Medically Necessary and Preventive Health Care Services listed in Part III, to which Members are entitled under a Health Maintenance Contract when provided or authorized in accordance with plan policy.

**“Creditable Coverage”** means benefits or coverage provided under:

- a. Medicare or Medicaid;
- b. An employer-based health insurance plan or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a health benefit plan;
- c. An individual health insurance policy;
- d. Chapter 55 of Title 10, United States Code;
- e. A medical care program of the Indian Health Service or of a tribal organization;
- f. A state health benefits risk pool;
- g. A health plan offered under Chapter 89 of Title 5, United States Code;
- h. A public health plan;
- i. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504)(e));
- j. College plan;
- k. A short-term limited-duration policy; or
- l. An organized delivery system.

**“Deductible”** means the amount as specified in the Schedule of Benefits that a Member must pay at the time Covered Services are received before the Plan will pay for such Covered Services. The deductible is calculated on a calendar year basis.

**“Dependent”** means the Spouse and any Dependent Child of a Subscriber.

**“Dependent Child”** means:

- a. the Subscriber’s biological child (including a child born out of wedlock), from the date of birth;
- b. A child lawfully adopted by the Subscriber or in the process of being adopted, from the date of placement;
- c. A stepchild of the Subscriber; or
- d. A foster child or any other child for whom the Subscriber has been granted legal custody.

**“Eligible Dependent”** means any “Dependent” who meets the specific eligibility requirements of the health benefit plan(s).

**“Eligible Employee”** means an employee who works on a full-time basis and has a normal work week of thirty (30) or more hours. It does not mean an employee who works on a part-time, temporary, or substitute basis.

**“Emergency” or “Emergency Condition”** means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the individual or, with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy; (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part.

**“Emergency Care”** means Health Care Services provided in the case of an Emergency Condition.

**“ESRD”** means the federal End Stage Renal Dialysis program.

**“Experimental or Investigational Services”** mean any Health Care Services where the Health Care Service in question either:

- a. is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or
- b. requires approval by any governmental authority and such approval has not been granted prior to the service being rendered.

**“The Group”** means the entity that sponsors this health maintenance agreement as permitted by IA Code 514B under which the Group Member is eligible and applied for this Contract.

**“Group Member”** means any employee, sole proprietor, partner, director, officer or Member of the Group.

**“Health Care Services”** mean any procedures, diagnoses, facilities or supplies furnished to a human being for the evaluation, diagnosis or treatment of pregnancy, illness or injury.

**“Hospital”** means a place licensed or recognized as a general, rehabilitation, or psychiatric hospital by the proper authority of the state in which it is located.

The term **“Hospital”** specifically excludes rest homes, places which are primarily for the care of convalescents, nursing homes, skilled nursing facilities, intermediate care facilities, health resorts, clinics, doctor’s offices, private homes, ambulatory surgical centers, residential or transitional living centers, or similar facilities.

## Part I - - Definitions

**“Hospitalization”** means a stay as an inpatient in a Hospital. Each “day” of Hospitalization includes an overnight stay for which a charge is customarily made.

**“Large Employer”** means a person actively engaged in business who, during at least fifty percent (50%) of the employer's working days during the preceding calendar year, employed more than fifty (50) full-time equivalent employees.

**“Medically Necessary”** means Health Care Services that are appropriate, in terms or type, frequency, level, setting, and duration, to the Member's diagnosis or condition, and diagnostic testing and preventive services. Medically Necessary care must:

- a. be consistent with generally accepted standards of medical practice as recognized by the Plan, as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and
- b. help restore or maintain the Members health; or
- c. prevent deterioration of the Member's condition; or
- d. prevent the reasonably likely onset of a health problem or detect an incipient problem; or
- e. not considered experimental or investigative

**“Member”** means any individual who is covered by the Plan.

**“Mental Health and Chemical Dependency Services”** mean Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSMM), current edition.

**“Natural Teeth”** means teeth which are whole or properly restored, are without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury (eating and chewing mishaps are not injuries for the purpose of this policy).

**“Non-Covered Services”** mean Health Care Services that are not Covered Services.

**“Nursing Services”** mean 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 Practitioner, and (3) not a Member of the Member's immediate family.

**“Open Enrollment”** means a period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan.

**“Participating Provider”** means that the Provider or someone on the Provider's behalf has signed a contract with the Plan to provide services to Members.

**“Non-Participating Provider”** means that the Provider has not signed such a contract with the Plan.

**“Physician”** means an individual licensed to practice medicine or osteopathy.

**“The Plan”** defined as Sanford Health Plan.

**“Practitioner”** means any individual or group of individuals licensed to practice the healing arts in the state where care is provided, including Physicians and any other category of Practitioners with whom the Plan has determined to contract.

**“Pre-Existing Condition”** means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six months immediately preceding the effective date of coverage or the first day of any waiting period if applicable. Pregnancy and genetic information in the absence of a condition related to such information are not considered Pre-Existing Conditions.

**“Preventive”** means Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan.

**“Primary Care Physician” (PCP)** means a Participating Physician who is an internist, family practice physician, pediatrician, or obstetrician/gynecologist who is a Participating Provider and who has been chosen to be designated as a Primary Care Physician as indicated in the Provider Directory and may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Member.

**“Provider”** means any Practitioner, group of Practitioners, hospital or any other institution or entity that furnishes Health Care Services and is licensed or otherwise authorized to render such services in the state where care is provided.

**“Reasonable Costs”** mean those costs that do not exceed the lesser of: (a) negotiated schedules of payment developed by the Plan which are accepted as payment in full by Participating Providers within the Plan's Service Area or (b) the prevailing marketplace charges.

**“Service Area”** means the geographic service area approved by the Iowa Division of Insurance.

**“Service Charge”** means the amount paid by the Group to the Plan on a monthly basis for coverage for Members under this Contract.

**“Small Employer”** means a person actively engaged in business who, on at least fifty percent (50%) of the employers working days during the preceding year, employed not less than two (2) and not more than fifty (50) full-time equivalent eligible employees. (In determining the number of eligible employees, companies which are affiliated companies or which are eligible to file a combined tax return for purposes of state taxation, are considered one employer).

**“Spouse”** means an individual who is a Subscriber's current lawful spouse under the laws of this State.

**“Subscriber”** means an Eligible Group Member who is enrolled in the Plan. A Subscriber is also a Member.

**“This Contract” or “The Contract”** means this Policy, including all attachments, the Group's application, and the applications of the Subscribers, if any, and the Health Maintenance Contract.

**“This State”** shall mean the State of Iowa.

## Part II - - Enrollment

### A. When to Enroll

To become a Subscriber, an Eligible Group Member must submit an enrollment application within the applicable Initial Enrollment Period or any Open Enrollment Period. The Initial Enrollment Period starts on the day the Group Member first becomes an Eligible Group Member, and ends *thirty-one (31)* days later. Open Enrollment is a period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan.

A "Late Member" is an Eligible Group Member or Dependent who requests enrollment in this Plan following the initial enrollment period or a special enrollment period described in Sections G and H below for which the Group Member or Dependent was eligible, unless any of the following apply:

1. The individual:
  - a. was covered under Creditable Coverage at the time the person was eligible to enroll;
  - b. has lost coverage under Creditable Coverage as a result of termination of employment or eligibility, reduction of hours, termination of the other plan's coverage, death of a spouse, or divorce; and
  - c. requests enrollment within *sixty-three (63)* days after the termination of the Creditable Coverage.
2. The individual is a Group Member of a Group that offers multiple health benefit plans and the individual elects a different health benefit plan during an Open Enrollment period.
3. A court has ordered coverage to be provided for a Dependent of a Subscriber under this Plan and a request for enrollment is made by or on behalf of the Dependent within *thirty (30)* days after issuance of the court order.

### B. How to Enroll

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

#### The Group must:

1. Submit a written request for coverage of the Group Member;
2. Provide all information needed by the Plan to determine eligibility; and
3. Agree to pay the required Service Charges on behalf of the Group Member.

#### The Group Member must:

1. Complete and sign the Plan's enrollment application form, requesting coverage for the Group Member and any Dependents, and
2. Provide all information needed to determine the eligibility of the Group Member and/or Dependents, if requested by the Plan.

### C. When Coverage Begins

Coverage generally becomes effective on the first day of the month that follows the date that the Plan receives the Group's written request to cover Group Members.

If all the requirements for coverage are not met immediately, the effective date of coverage may be delayed. However, this delay may not exceed *thirty-one (31)* days from the date that all coverage requirements are met.

Health Care Services that are covered under an extension of benefits from a previous group health plan or other coverage

arrangement will not be covered under this Contract until the extension under the prior plan ends.

### D. Eligibility Requirements for Dependents

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

#### Spouse

A Spouse is always eligible for coverage, subject to the limitations set forth below.

#### Dependent Child

To be eligible for coverage, a Dependent Child must meet all the following requirements:

1. Be unmarried;
2. Receive more than half of his or her support from the Subscriber; and
3. Be one of the following:
  - a. under nineteen (19) years old; or
  - b. under twenty-five (25) years old and enrolled in and attending an accredited college, university, or trade or secondary school on a full-time basis. For the purpose of the Plan, the school's definition of "full-time student" shall be used to determine if a dependent is a full time student.; or
  - c. incapable of self-sustaining employment and dependent on her or his parents or other care providers for lifetime care and supervision because of a disabling condition that was present before the child was nineteen (19) (or twenty-five (25), if a full-time student). 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.

**Noncustodial Subscribers.** Whenever a Dependent Child receives coverage under the Plan through the noncustodial parent who is the Subscriber, the Plan shall do all of the following:

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

**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.

#### Qualified Medical Child Support Order (QMCSO) Provision

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

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

- Name and last known address of the Member and the child(ren) to be covered by the Plan.
- A description of the type of coverage to be provided by this Plan to each named child.
- The applicable period determined by the order.

## Part II - - Enrollment

- The plan determined by the order.

In order for the child's coverage to become effective as of the date of the court order issued, the Member must apply for coverage as defined previously in this section. Each named 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 in Section D, A(1-3) need not be satisfied, but the Subscriber must still request enrollment on behalf of the Dependent Child as set forth in this Plan. 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 disenrolled unless the 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 is or will be enrolled in comparable health coverage through an insurer which will take effect not later than the effective date of the disenrollment; or
3. The Group has eliminated family coverage for all of its Members.
4. The member is no longer paying the required premium because the employer no longer owes the Member compensation, or because the Member's employer has terminated and the Member has not elected to continue coverage.

### E. When 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", (Part III, Section G) and "Children Placed for Adoption" (Part IV, Section G). There is also an exception for Spouses; see "New Spouses" (Part V, Section G.).

### F. How to Enroll Dependents

A Subscriber must:

1. Agree to make the required Service Charge, if any; and
2. Complete and sign the Plan's enrollment application form requesting coverage for the Dependent(s).

### G. When Dependent Coverage Begins

#### 1. General

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

#### 2. Delayed Effective Date of Dependent Coverage

Except for newborns (see "Coverage from Birth" (Part III Section G) below), if, on the date dependent coverage becomes effective, the Dependent is hospitalized and covered under an extension of health benefits from a previous group health plan or other coverage arrangement, coverage under this Contract for Hospitalization shall not begin until the extension under the prior coverage ends.

#### 3. Coverage from Birth

If a Subscriber, or a Group Member who is eligible to be enrolled in the Plan, but has failed to enroll during a previous enrollment period, has a child through birth, the child will become a covered Dependent from the date of

birth, provided that coverage is applied for the child and the required Service Charge payments are made within *thirty-one (31)* days from the date of birth. If applicable, the Group Member will become covered from the date of birth provided that coverage is applied for the Group Member, within *thirty-one (31)* days of the birth and that the required Service Charge payments are made.

In the case of a Group Member who is eligible to be enrolled in the Plan, but failed to enroll during a previous enrollment period, the Group Member shall be covered under this Contract from the date of birth, provided that coverage is applied within *thirty-one (31)* days and the required Service Charge payments are made.

In such situations, Dependent coverage is available for the Spouse if the Spouse is otherwise eligible for coverage, provided that coverage is applied for the Spouse and, if applicable, the Group Member within *thirty-one (31)* days of birth and the required Service Charge payments are made.

#### 4. Adoption or Children Placed for Adoption

If a Subscriber, or a Group Member who is eligible to be enrolled in the Plan, but failed to enroll during a previous enrollment period, adopts a child or has a child placed with him or her as a Dependent, that child will become covered as a Dependent from the date of adoption or beginning of the *six (6)* month adoption bonding period, as noted in the legal adoption papers, provided that coverage is applied for the child and, if applicable, the Group Member within *thirty-one (31)* days of the date of adoption or the beginning of the *six (6)* month adoption bonding period and the required Service Charge payments are made.

In the case of a Group Member who is eligible to be enrolled in the Plan, but failed to enroll during a previous enrollment period, the individual shall be covered from the date of adoption or the beginning of the *six (6)* month adoption bonding period, as noted in the legal adoption papers, provided that coverage is applied for the Group Member within *thirty-one (31)* days of the date of adoption or the beginning of the *six (6)* month adoption bonding period and the required Service Charge payments are made.

If a child placed for adoption is Hospitalized on the day that coverage would otherwise end, coverage will continue beyond the *thirty-first (31<sup>st</sup>)* day through the end of that hospital stay.

In such situations, Dependent coverage is available for the Spouse if the Spouse is otherwise eligible for coverage, provided that coverage is applied for the Spouse and, if applicable, the Group Member within *thirty-one (31)* days of the date of adoption or the beginning of the *six (6)* month adoption bonding period and the required Service Charge payments are made.

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

#### 5. New Spouses and Dependent Children

If a Subscriber, or a Group Member who is eligible to be enrolled in the Plan, but failed to enroll during a previous enrollment period, gets married, his or her Spouse and any of the Spouse's dependents who become Eligible Dependents of the Group Member as a result of the marriage will become covered as a Member from the first day of the calendar month beginning after

## Part II - - Enrollment

the date coverage is applied for, provided that coverage is applied for the Spouse and/or the dependent children and, if applicable, the Group Member within *thirty-one (31)* days of the date of marriage and the required Service Charge payments are made.

In the case of a Group Member who is eligible to be enrolled in the Plan, but failed to enroll during a previous enrollment period, the individual shall be covered from the first day of the calendar month beginning after the date coverage is applied for, provided that coverage is applied for within *thirty-one (31)* days of the date of marriage and the required Service Charge payments are made.

### **H. Special Enrollment for Individuals Losing Other Coverage**

Any Eligible Group Member or Eligible Dependent of an Eligible Group Member who has failed to enroll in the Plan during a previous enrollment period and has lost prior coverage shall be able to enroll in the Plan within *thirty (30)* days after the date of exhaustion of the previous coverage provided that the following conditions are met:

1. The Eligible Group Member or Eligible Dependent was covered under a group health plan or had health insurance coverage at the time coverage was previously offered to the Eligible Group Member or Eligible Dependent;
2. The Eligible Group Member stated in writing at such time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the Group required such a statement at such time and provided the individual with notice of such requirement at such time;
3. The Eligible Group Member's or Eligible Dependent's previous coverage:
  - a. was under a COBRA or state continuation provision and the coverage under such provision was exhausted; or
  - b. was not under such a provision and either the coverage was terminated as a result of loss of eligibility for coverage or employer contributions toward such coverage were terminated; and
4. Under the terms of the Plan, the Eligible Group Member requests enrollment in the Plan not later than *thirty (30)* days after the date of exhaustion or termination of coverage as described in three (3) above.

## Part III -- Covered Services

### A. Preconditions for Coverage

Members shall be entitled to coverage for the Health Care Services listed in Part III, Section C, "Covered Services," that are:

1. Medically Necessary and/or Preventive; and
2. Received from or provided under the orders or direction of a Participating Provider, or approved by the Plan. However, this specific condition does not apply for Emergency 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 Provider. Appropriate access for Primary Care Physicians and Hospital Provider sites is within *thirty (30)* miles of a Member's city of residence. For other Participating Providers such as Specialty Physicians, Diagnostic Service Centers, Nursing Homes, Rehabilitation Providers, and Mental Health/Substance Abuse Providers, appropriate access is within *ninety (90)* miles of a Member's city of residence. Appropriate access includes access to Participating Providers when the Member has traveled outside of the service area. If you are traveling within the service area where other Participating Providers are available then you must use Participating Providers.

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

#### In addition, all Health Care Services are subject to:

1. The exclusions and limitations described in Part IV "Non-Covered Services"; and
2. Any applicable Copay, Deductible, and Coinsurance amount as stated in the attached Summary of Plan Benefits.

### B. PRIOR AUTHORIZATION OF SERVICES

Prior authorization is the urgent or non-urgent authorization of a requested service prior to receiving the service. Prior authorization (or precertification/pre-service decisions) is designed to facilitate early identification of the treatment plan to ensure medical management and available resources are provided throughout an episode of care.

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

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

The Member is ultimately responsible for obtaining prior authorization from the Health Services Department in order to receive In-Network coverage. However, information provided by the provider's office will also satisfy this requirement. Primary care physicians and any Participating Specialists have been given instructions on how to get the necessary authorizations for surgical procedures or hospitalizations you may need.

#### 1. Services that Require Prior Authorization Include:

- Inpatient hospital admissions including admissions for medical,

surgical, obstetric, mental health and chemical dependency services;

- Selected Outpatient Surgeries;
- Physician office site surgical center, including surgical dental care procedures;
- Home Health, Hospice and Home IV therapy services;
- Durable Medical Equipment (rental or purchase over \$200);
- Rehabilitative services; including speech, occupational and physical therapy and one to one water therapy;
- Skilled nursing and sub-acute care;
- Organ transplants; (*NOTE: Organ transplants are not covered for Small Employer Group Basic Plan Members*) Ambulance Services for non-emergency situations; and
- Referrals to Non-Participating Providers which are recommended by Participating Providers. Prior authorization is required for the purposes of receiving In-Network coverage only. If prior authorization is not obtained for referrals to Non-Participating Providers, the services will be covered at the Out of Network coverage level. Prior authorization 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 your Policy Part III, Section A.

#### 2. Prior Authorization Process For Elective Inpatient Hospitalizations, Non Urgent Care, Pharmaceutical Decisions and Behavioral Health

All requests for prior authorization are to be made by the member or physician's office at least *three (3)* business days prior to the scheduled admission or requested service. In the event that Health Care Services need to be provided within less than *three (3)* business days, Members should contact the Health Services Department to request an expedited review. The Health Services 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:

- a) Patient medical information including:
  - diagnosis
  - medical history
  - presence of complications and/or co-morbidities;
- b) Consultation with the treating physician, as appropriate;
- c) Availability of resources and alternate modes of treatment; and
- d) For admissions to facilities other than acute hospitals additional information may include but are not limited to the following:
  - history of present illness
  - patient treatment plan and goals
  - prognosis
  - staff qualifications
  - twenty-four (24)* hour availability of staff.

The Plan's Health Services Department is available between the hours of 8:00a.m. and 5:00p.m. Central Time, Monday through Friday, by calling the Plan's toll-free number 1-800-805-7938 or (650)328-6807. After hours you may leave a message on the confidential voice mail of the Health Services Department and someone will return your call.

**You are ultimately responsible for obtaining prior authorization from the Health Services Department. Failure to obtain prior authorization will result in a reduction to the Out of Network benefits level.** However, information provided by the physician's office also satisfies this requirement.

## Part III -- Covered Services

The Health Services Department will review the Member profile information against standard criteria. A determination for *elective inpatient or non urgent care* will be made by the Health Services Department *within fifteen (15) calendar days* of receipt of the request including the collection of information.

If the Health Services Department is unable to make a decision *due to matters beyond its control*, it may extend the decision time frame once, for up to *fifteen (15) calendar days*. Within *fifteen (15) calendar days* of the request for authorization, Sanford Health Plan must notify the Member or Member's authorized representative of the need for an extension and the date by which it expects to make a decision.

If the Health Services Department is unable to make a decision *due to lack of necessary information*, it must notify the Member or the Member's authorized representative of what specific information is necessary to make the decision *within fifteen (15) calendar days* of the prior authorization request. Sanford Health Plan must give the Member or the Member's authorized representative *forty-five (45) calendar days* to provide the specified information. In lieu of notifying the Member, the Plan can notify the practitioner of the information needed if the request for healthcare services came from the practitioner.

The prior authorization determination shall either be authorization of the requested service or additional review will be needed by the Plan Medical Director.

Sanford Health Plan will give oral, electronic or written notification of the *determination to authorize* the service *within fifteen (15) calendar days* of the request to the Member, attending practitioner and those providers involved in the provision of the service. The Health Services Department will assign an authorization/certification number for the approved service.

If the Health Services Department is unable to make a decision *due to lack of necessary information*, it must notify the Member or the Member's authorized representative of what specific information is necessary to make the decision *within fifteen (15) calendar days* of the prior authorization request. Sanford Health Plan must give the Member or the Member's authorized representative *forty-five (45) calendar days* to provide the specified information. In lieu of notifying the Member, the Plan can notify the practitioner of the information needed if the request for healthcare services came from the practitioner. The decision time period is suspended from the date of the notification to the Member or practitioner as applicable, until the earlier of the date on which the Plan receives any information from the Member or practitioner or *forty-five (45) days* after the notification to the Member or practitioner. If the information is not received by the end of *the forty-five (45) calendar day* extension Sanford Health Plan will deny the request.

Sanford Health Plan will deny any request if it does not receive the information to make a decision within this time frame. At this point, the Member can request an appeal. Refer to the "Member Complaint and Appeals Procedures" for details.

Sanford Health Plan will give electronic or written notification of the *determination to deny* the service *within fifteen (15) calendar days* of the request to the Member, attending practitioner and those providers involved in the provision of the service. Upon request the Plan will provide the attending physician and or provider with the criteria used

to determine the necessity, appropriateness, and efficacy of the health care service.

### 3. Prior Authorization for Urgent/Emergency Conditions

Prior authorization (pre-service) is not required for emergency conditions. However, the Plan must be notified as soon as reasonably possible and no later than *forty-eight (48) hours* after physically or mentally able to do so. Additionally, because of the inability to predict admission, obstetrical admissions shall be authorized when the pregnancy is confirmed. The exception is that of an elective C-section, which must be prior authorized as an elective admission.

For urgent care prior authorization, the determination will be made by the Health Services Department within *seventy-two (72) hours* of receipt of the request. For *approval decisions*, the Plan will give oral, electronic, or written notification of the decision to practitioners and Members *within seventy-two (72) hours* of the request.

If the Health Plan is unable to make a decision due to lack of necessary information it will extend the decision time frame once, for up to *forty-eight (48) hours*. Within *twenty-four (24) hours* of the Health Plans request to extend the decision time frame, it will notify the Member or the Member's authorized representative of what specific information is necessary to make the decision. In lieu of notifying the Member, the Plan can notify the practitioner of the information needed if the request for healthcare services came from the practitioner.

For urgent care prior authorization *denials*, the Plan will give electronic or written notification of the decision to practitioners and Members *within seventy-two (72) hours* of the request. The Plan may provide an initial oral notification of the denial decision orally within *seventy-two (72) hours* of the request, provided that an electronic or written notification is given no later than *three (3) calendar days* after the oral notification.

### 4. Authorization of Concurrent review

Concurrent review (i.e. inpatient hospitalization or ambulatory care) is utilized when a request for an extension of an approved ongoing course of treatment over a period of time or number of treatments is warranted. Sanford Health Plan will follow the same time frame as for prior authorization of services for a concurrent review decision. Additional stay days must meet the continued stay review criteria and, if acute level of care criteria are not met, a decision to authorize further treatment must be made at that time. Authorization of the hospital or behavioral healthcare stays will terminate on the date the Member is to be discharged from the hospital or behavioral healthcare facility (as ordered by the attending physician). Hospital/facility days accumulated beyond ordered discharge date will not be authorized unless the continued stay criteria continues to be met. Charges by providers associated with these non-authorized days will be considered non-covered. The Plan Medical Director or a psychiatrist reviews all cases that may lead to denial and those that are denied. If the request is *authorized* for urgent concurrent review, Sanford Health Plan will make the decision and notify the practitioner and Member by oral, electronic or written notification *within twenty-four (24) hours* of the receipt of the request.

If the request to extend urgent concurrent review is not made at

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least *twenty-four (24) hours* prior to the expiration of the prescribed period of time or number of treatments, Sanford Health Plan will treat it as an urgent prior authorization decision and make the decision within *seventy-two (72) hours*. Sanford Health Plan will continue treatment without liability to the Member until it notifies the Member of the decision, unless the treatment was not initially approved or authorized.

For urgent care concurrent review *denials*, the Plan gives electronic or written notification of the decision to practitioners and Members *within twenty-four (24) hours* of the request. The Plan may provide an initial oral notification of the denial decision orally *within seventy-two (72) hours* of the request, provided that an electronic or written notification is given no later than *three (3) calendar days* after the oral notification.

### 5. Authorization of Retrospective Review (Post-service)

Retrospective review will be utilized by Sanford Health Plan to review services that have already been utilized by the Member. The Plan will review the request and make the decision to *approve or deny within thirty (30) calendar days* of receipt of the request.

If the Health Services Department is unable to make a decision *due to matters beyond its control*, it may extend the decision time frame once, for up to *fifteen (15) calendar days*. Within *thirty (30) calendar days* of the request for authorization, Sanford Health Plan must notify the Member or Member's authorized representative of the need for an extension and the date by which it expects to make a decision.

For retrospective review *denial decisions*, Sanford Health Plan will give electronic or written notification of the decision to practitioners and Members *within thirty (30) calendar days* of the request.

### C. Levels of Coverage

There are *two (2)* levels of coverage that are available, In Network Coverage and Out of Network Coverage, which are both described below. As indicated in the Summary of Plan Benefits, for Out of Network Coverage, the Plan will pay a percentage of the Reasonable Cost after credit is given for payment of the applicable Copays, Deductibles, and Coinsurance, provided that the Plan determines that the billed charges are reasonable. If the Plan determines that the billed charges are not reasonable, the Plan will only pay a percentage of the Reasonable Costs. Percentage amounts are indicated on the Summary of Plan Benefits.

1. **In Network Coverage.** In Network Coverage means Covered Services that are either received:
  - a. from a Participating Provider,
  - b. in an Emergency Condition or an urgent care situation,
  - c. when the Member does not have appropriate access to a Participating Provider, or
  - d. when a Participating Provider has recommended, and the Plan has authorized the referral to, a Non-Participating Provider. Appropriate access for Primary Care Physicians and Hospital Provider sites is within *thirty (30) miles* of a Member's residence and for other Providers it is within *ninety (90) miles* of a Member's residence.
2. **Out of Network Coverage.** Out of Network Coverage means Covered Services that do not fit the definition of In Network Coverage set forth above. All Out of Network services are subject

to Reasonable Cost. Specifically, Out of Network Coverage means Covered Services that are received:

- a. from Non-Participating Providers when appropriate access to a Participating Provider is available;
- b. when the Plan has not authorized the referral to a Non-Participating Provider; or
- c. for a non-emergency or non-urgent care situation.

### D. Covered Services

The following Health Care Services are Covered Services:

1. **Addiction/Abuse Services includes Alcohol, Chemical, and Gambling Treatment.** Inpatient coverage is limited to thirty days' care per calendar year with a *ninety (90) day* lifetime maximum for inpatient treatment of alcoholism at any Iowa-approved inpatient alcohol treatment facility. Outpatient coverage is limited to thirty days' care per calendar year and includes intensive outpatient treatment programs.
2. **Ambulatory Surgical Center Services.** Health Care Services furnished in connection with a surgical procedure performed in a participating Ambulatory Surgical Center
3. **Ancillary Services** including laboratory, x-rays, and other diagnostic tests including infertility testing.
4. **Anesthesia Services.** Services of an anesthesiologist or other certified anesthesia provider for the administration of anesthesia.
5. **Casts, Splints, Braces, Crutches, and Dressings** that are part of treatment received in a Physician's office, emergency room, or as part of an approved Hospital treatment for the diagnosis of fracture, dislocation, torn muscles and/or ligaments only.
6. **Child Care Wellness Services**  
Pediatric preventive services visits including: periodic examinations (including hearing and vision screening performed during the periodic examination), diagnostic procedures, and laboratory testing, as outlined by the Plan Preventative Health Guidelines. For children through age six (6) years old, benefits shall be provided at the following age intervals: two (2) weeks, two (2) months, four (4) months, six (6) months, nine (9) months, twelve (12) months, fifteen (15) months, eighteen (18) months, twenty-four (24) months, three (3) years, four (4) years, five (5) years and six (6) years.
7. **Dental Services** required because of injury, accident, or cancer that damages sound natural teeth (this does not include replacements including crowns, bridges, braces or implants), as long as the patient was covered under the Plan during the time of the injury or illness causing the damage and receives care within 12 months months of the occurrence. Associated radiology services are included. "Injury" does not include injuries to natural teeth caused by biting or chewing.  
  
Anesthesia and hospitalization charges for dental care are covered for covered persons who:
  - a. is a child under five years of age upon a determination by a licensed dentist and the child's treating physician that such child requires necessary dental treatment in a hospital or ambulatory surgical center due to a dental condition or a developmental disability for which patient management in the dental office has proved to be ineffective; or
  - b. upon a determination by a licensed dentist and the Member's

## Part III - - Covered Services

treating physician, that Member has one or more medical conditions that would create significant or undue medical risk for the Member in the course of delivery of any necessary dental treatment or surgery if not rendered in a hospital or ambulatory surgical center.

Such coverage applies regardless of whether the services are provided in a Hospital or a dental office.

- 8. Diabetic Coverage.** Diabetes supplies, equipment, and education to include:
- Blood glucose monitors
  - Blood glucose monitors for the legally blind
  - Test strips for glucose monitors
  - Urine testing strips
  - Insulin injection aids
  - Lancets and lancet devices
  - Insulin pumps and all supplies for the pump
  - Syringes
  - Insulin infusion devices
  - Prescribed oral agents for controlling blood sugars
  - Glucose agents
  - Glucagon kits
  - Insulin measurement and administration aids for the visually impaired and other medical devices for the treatment of diabetes.

Diabetes self management training and education shall be covered if:

- the service is provided by a Physician, nurse, dietitian, pharmacist or other licensed health care 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;
- certifies that such services are needed under a comprehensive plan of care related to the individual's diabetic condition to ensure therapy compliance or to provide the individual with necessary skills and knowledge to participate in the management of the individual's condition, and;
- the training and education is based upon a curriculum certified by the Iowa Department of Public Health.

Coverage of diabetes self-management training is limited to:

- persons who are newly diagnosed with diabetes or have received no prior diabetes education;
- persons with poor glycemic control as evidenced by glycosylated hemoglobin of nine and five-tenths or more in the ninety (90) days before attending the training;
- persons who require a change in current regimen from no diabetes medication to any diabetes medication, or from oral diabetes medication to insulin; ;
- persons with documented acute episodes of severe hypoglycemia or acute severe hyperglycemia occurring in the past year during which person needed third-party assistance for either ER visits or hospitalization;
- persons with documented lack of feeling in the foot or other foot complications such as foot ulcer or amputation, pre-proliferative or proliferative retinopathy or prior laser treatment of the eye, or kidney complications related to diabetes.

A Member who qualifies for initial outpatient diabetes self management training shall be covered for up to ten (10) hours of training within a continuous twelve (12) month period. Members who receive initial training shall be eligible for a single follow-up training session of up to one (1) hour each year.

Coverage is limited to the closest available in-network qualified education program that provides the necessary management training to accomplish the prescribed treatment.

- 9. Dialysis** for renal disease, unless or until the Member qualifies for federally funded dialysis services under ESRD. Services include equipment, training, and medical supplies required for effective dialysis care. Coordination of Benefit Provisions apply, see Part IX Section F.
- 10. Durable Medical Equipment**, covered equipment prescribed by an attending Physician 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 policy guidelines apply.
- 11. Education Programs. Health education programs** approved by the Plan including, but not limited to, smoking cessation, and nutritional education.
- 12. Emergency Services, Urgent Care Situations and Out of Area Services**
- Emergency Services.** If an Emergency Condition arises, Members should proceed to the nearest emergency facility that is a Participating Provider. If the Emergency Condition is such that a Member cannot go safely to the nearest participating emergency facility, then the Member should seek care at the nearest emergency facility. The Member or a designated relative or friend must notify the Plan and the Member's Primary Care Physician, 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. The Health Plan covers emergency services necessary to screen and stabilize Members without precertification in cases where a prudent layperson, acting reasonable, believed that an emergency medical condition existed. With respect to care obtained from a nonparticipating provider within the Plan's service area, the Plan shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization 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 provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.
  - Urgent Care Situations.** 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 a participating urgent care or after hour's clinic.

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If a Member is admitted, the Member or a designated relative or friend must notify the Plan and the Member's Primary Care Physician, 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. If a Member is admitted to a Non-Participating facility, then the Plan will contact the admitting Physician to determine medical necessity and a plan for treatment. In some cases, where it is medically safe to do so, the Member may be transferred to a Participating Hospital. With respect to care obtained from a nonparticipating provider within the Plan's service area, the Plan shall cover emergency services necessary to screen and stabilize a covered person and may not require prior authorization 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 provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

- c. Ambulance Service.** The Plan covers local ambulance services for the following:
- emergency transfer to a Hospital or between Hospitals.
  - approved planned transfer to a Hospital or between Hospitals.
  - approved transfer from a Hospital to a nursing facility.

Planned transfers to a Hospital or between Hospitals and transfers from a Hospital to a nursing facility will be covered only when determined by the Plan to be Medically Necessary either before or after the ambulance is used. The Plan does not cover charges for an ambulance when used as transportation to a doctor's office for an appointment.

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

If an urgent care situation occurs when traveling outside of the Plan's Service Area, Members should contact their Primary Care Physician immediately, if one has been selected, and follows his or her instructions. If a Primary Care Physician has not been selected, the Member should contact the Plan and follow the Plan's instructions. Coverage will be provided for urgent care situations outside the Service Area (at the In Network level) unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

Out of Network Coverage will be provided for non-emergency medical care or non-urgent care situations when traveling outside the Plan's Service Area unless care is available by a Participating Provider.

- 13. Eyeglasses or Contact Lenses** for aphakic patients or soft contact lenses or scleral shells intended for the use in the treatment of a disease or injury (*one (1)* pair per Calendar Year).
- 14. Family Planning Services**, including consultations, and pregnancy planning.
- 15. Fibrocystic Disease**, including treatment for breast and uterine fibroids.
- 16. Home Health Services** if approved by the Plan in lieu of hospital or nursing facility. Home care limited to 40 visits in a 12 consecutive month period and does not include meals, custodial care or housekeeping. The Member must be home-bound to receive this care. The following Home Health Services are Covered Services:
  - 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.
- 17. Hospice Services.** 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 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);
  - the Member continues to meet the terminally ill prognosis as reviewed by the Plan's Medical Director over the course of care; and
  - the hospice service has been approved by the Plan, and

*The following Hospice Services are Covered Services:*

  - admission to a hospice facility, Hospital, or nursing facility for room and board, supplies and services for pain management and other acute/chronic symptom management.
  - part-time or intermittent nursing care by a RN, LPN/LVN, or home health aid for patient care up to *eight (8)* hours per day.
  - social services under the direction of a Participating Practitioner.
  - psychological and dietary counseling.
  - physical or occupational therapy, as described above under Specific Therapies (see Part III, Section D-11).
  - consultation and case management services by a Participating Practitioner.
  - medical supplies and drugs prescribed by a Participating Practitioner.
  - expenses for Participating Practitioners 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 above (see "Specific Therapies" Part III, Section D), but only where the hospice retains responsibility for the care of the Member.

## Part III - - Covered Services

### 18. Hospital Services

The following Hospital Services are covered:

- a. room and board for a ward or semi-private room (room and board for a private room will be covered only when approved by the Plan).
- b. critical care services.
- c. use of the operating room and related facilities.
- d. general Nursing Services, including special duty Nursing Services if approved by the Plan.
- e. 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*.
- f. special diets during Hospitalization, when specifically ordered.
- g. other services, supplies, biologicals, drugs and medicines prescribed by a Physician during Hospitalization.

### 19. Maternity Services (excluding maternity services for dependent children)

Maternity care including prenatal through postnatal maternity care, delivery and care for complication of pregnancy of mother, and care for the newborn child from the moment of birth including care for illness, injury, congenital defects, birth abnormalities, and premature birth. The Plan shall not terminate inpatient benefits or require discharge of a mother or the newborn from the hospital following delivery earlier than determined to be medically appropriate by the attending Physician after consultation with the mother and in accordance with the Guidelines for Perinatal Care, Third Edition, 1992, by the American Academy of Pediatrics and the American College of Obstetrics and Gynecologists. The minimum inpatient hospital stay, when complications are not present, ranges from a minimum of *forty-eight (48)* hours for a vaginal delivery to a minimum of *ninety-six (96)* hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Physician, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If such an inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by Participating Providers competent in postpartum care and newborn assessments.

### 20. Medical Supplies, such as ostomy and surgical supplies.

**21. Mental Illness (Biologically-Based).** Any mental illness which current medical research affirms is caused by a neurobiological disorder of the brain and which substantially impairs perception, cognitive function, judgment, and emotional stability and which limits the life activities of the person with the illness. This includes schizophrenia; schizo affective disorder; bipolar affective disorder; major depression; obsessive-compulsive disorder, and other anxiety disorders which cause significant impairment of function; and other disorders proven to be biologically-based mental illnesses. These are covered just like Health Care Services for any other condition. Biologically-based mental illnesses will be covered for treatment and diagnosis with the same dollar limits, deductibles, coinsurance factors, and restrictions as for other covered illnesses. Inpatient coverage is limited to thirty days' care per calendar year with a *ninety (90)* day lifetime maximum for inpatient treatment. Outpatient coverage is limited to thirty days' care per calendar year and

includes intensive outpatient treatment programs.

**22. Newborn Health Care Services** for injury or sickness including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities.

**23. Organ Transplants** for human organs only, and only for the following: (NOTE: Organ transplants are not covered for Small Employer Group *Basic Plan Members*)

- a. Cornea.
- b. Heart.
- c. Heart/Lung.
- d. Kidney.
- e. Liver.
- f. Lung (single and bilateral).
- g. Pancreas
- h. both allogenic (donor) and autologous (self) bone marrow transplants for:
  - i. Acute non-lymphocytic leukemia;
  - ii. Advanced Hodgkin's lymphoma;
  - iii. Advanced non-Hodgkin's lymphoma;
  - iv. Advanced neuroblastomas; and
  - v. Testicular, mediastinal, retroperitoneal and ovarian germ cell tumors.
- i. in addition, autologous bone marrow transplants for solid tumors such as breast cancer.
- j. high dose chemotherapy with bone marrow transplantation for the approved treatment of solid tumors, such as breast cancer.
- k. prescribed post-transplant immunosuppressant outpatient drugs required as a result of a covered transplant.
- l. coverage includes up to \$25,000 for acquisition fee.
- m. medical expenses for the organ donor which are necessary for the transplant, and which are not covered by another group health plan or other coverage arrangement.

**24. Phenylketonuria.** Testing, diagnosis and treatment of Phenylketonuria including dietary management, formulas, case management, intake and screening, assessment, comprehensive care planning and service referral.

### 25. Physician Services, including:

- a. physician office visits;
- b. physician inpatient visits;
- c. consultations; and
- d. surgical care.

**26. Prosthetic Devices** permanently implanted that are not Experimental or Investigational.

**27. Nursing Facility Services** if approved by the Plan in lieu of continued or anticipated hospitalization. The following Nursing facility Services are covered when provided through a state licensed nursing facility or program:

- a. Skilled nursing care, whether provided in an inpatient skilled nursing unit, a nursing facility, or in a home health care program.
- b. Room and board in a nursing facility.
- c. Special diets in a nursing facility, if specifically ordered.

Nursing facility care is limited to *thirty (30) days in a twelve (12) consecutive month period*. Skilled nursing care in a hospital shall be covered if the level of care needed by a

## Part III -- Covered Services

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 health care facility within a *thirty-mile (30)* radius of the hospital.

### 28. Treatment Therapies to include:

- a. Inhalation Therapy.
- b. Radiation Therapy.
- c. Chemotherapy, regardless of whether the Member has separate prescription drug benefit coverage.
- d. Outpatient Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitative services directed at improving physical functioning of the Member) which is expected to provide significant improvement within *two (2)* months, as authorized on a prospective and timely basis by the Plan. Coverage is limited to *thirty (30)* visits per therapy per Calendar Year.
- e. Non-Surgical Spinal Treatments or Chiropractic Services performed by a chiropractor or other licensed Provider authorized to perform such services.

29. **Reconstructive Breast Surgery, Prostheses,** and physical complications at all stages of a mastectomy, including lymphedemas are covered for those Members who had a mastectomy covered by this Plan, resultant from a disease, illness, or injury. For single mastectomy: coverage extends to the non-affected side to make it similar in size to the affected breast post-surgical reconstruction. Includes *one (1)* external prosthesis per lifetime and *two (2)* bras per Calendar Year. For double mastectomy: Coverage extends to *two (2)* external prosthesis per lifetime and *two (2)* bras per Calendar Year.

30. **Restorative Surgery** only to restore bodily function or correct a deformity.

31. **Sterilizations. Voluntary sterilization** including tubal ligations and vasectomies.

### 32. Transportation Services

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

- a. Medically Necessary; and
- b. to the nearest Participating Hospital equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by the Plan.

### 33. Wellness Services

- a. periodic preventive adult physical examinations including periodic diagnostic procedures, laboratory testing, diagnostic imaging (as outlined in the Plan Preventative Health Guidelines), and Plan approved health education services for disease prevention and identification.
- b. periodic preventive services visits including: periodic examinations (including hearing and vision screening performed during the periodic examination), diagnostic procedures, and laboratory testing, as outlined by the Plan Preventative Health Guidelines for children ages seven ( 7) to eighteen (18) and plan approved health education services.
- c. medically accepted methods of prophylaxis or diagnosis

which prevent disease or provide early diagnosis of illness, including administration of medically accepted pediatric and adult immunizations and injections (excluding self-Injectible drugs).

- d. screening Mammography, as follows:
  - i. one baseline mammography between the ages of thirty-five (35) to thirty-nine (39).
  - ii. annually after the fortieth (40<sup>th</sup>) birthday.
  - iii. screenings may be more frequent if there is a family history of breast cancer or as approved by the Plan.
- e. annual gynecological examinations by a Participating Physician including a Pap smear test.
- f. prostate cancer screening for all men fifty (50) years or older, and for men forty (40) years and older who are symptomatic or in a high risk category.

## Part IV - - 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 services.

### A. General Exclusions

1. 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.
2. Health Care Services performed by any Provider who is a Member of the Member's immediate family, including any person normally residing in the Member's home. This exclusion does not apply in those areas in which the immediate family Member is the only Provider in the area. If the immediate family Member is the only Participating Provider in the area, the Member may go to a Non-Participating Provider and receive in network coverage (Part III, Section C). 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.
3. Physical examinations including:
  - a. school physicals;
  - b. sports physicals;
  - c. pre-employment and employment physicals;
  - d. insurance physicals; or
  - e. government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses).
4. Health Care Services received for any disease or injury suffered as a result of or while in military service.
5. Health Care Services for injury or disease due to voluntary participation in a riot.
6. Health Care Services for sickness or injury sustained in the commission of a felony .
7. Health Care Services ordered by a court or as a condition of parole or probation received from an Out of Network Provider.
8. Experimental and Investigational services, treatment, drugs or devices.
9. Services that are not Health Care Services.
10. Treatment for intentionally self-inflicted injuries.
11. Genetic Testing Services
12. Complications from a non-covered procedure or service (except complications of maternity care for dependent children is covered as for any other illness).
13. Charges for telephone calls to or from a physician, hospital or other medical provider.

### B. Exclusion of Specific Health Care Services

1. **Acupuncture, Acupressure, Aquatic Whirlpool Therapy, Biofeedback, Massage Therapy, Fluidotherapy, Naturopathy, Homeopathy, Holistic Medicine or Therapeutic Touch.**

2. **Ambulance Services and/or Transportation.** Non-Emergency Ambulance Services and/or transportation unless approved and arranged by the Plan.
3. **Corns, Calluses, or Nail treatment. Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized corrective surgery.**
4. **Cosmetic Services** and/or supplies to repair or reshape a body structure primarily for the improvement of a covered person'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.
5. **Counseling Services**, including:
  - a. marriage counseling;
  - b. family counseling (unless specifically covered elsewhere);
  - c. bereavement counseling;
  - d. pastoral counseling;
  - e. financial counseling;
  - f. legal counseling; and
  - g. custodial care counseling.
6. **Custodial care, convalescent care, intermediate level care, domiciliary care, residential care, rest cures or care, or services to assist in activities of daily living.**
7. **Developmental Care** including services or supplies, regardless of where or by whom they are provided which:
  - a. Are provided to a Member who has not previously reached the level of development expected for the Member's age in the following areas of major life activity:
    - Intellectual;
    - Physical;
    - Receptive and expressive language;
    - Learning;
    - Mobility;
    - Self-direction;
    - Capacity for independent living;
    - Economic self-sufficiency; or
  - b. Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness); or
  - c. Are educational in nature.

Care for congenital defects and/or birth defects is not considered to be developmental care. Sanford Health Plan's Health Services Department will determine what services or supplies is Developmental Care.
8. **Dietary Regimen and Treatment for Reducing or Controlling Weight**, including obesity treatment, exercise programs, bariatric treatment centers, and prescription drugs for the purposes of reducing and controlling weight. Panniculectomy or sequela as result of gastric bypass surgery is not covered.
9. **Education Programs or Tutoring Services** not specifically defined elsewhere (including, but not limited to, education on self-care or home management).
10. **Flat Feet. Diagnosis and Treatment of Weak, Strained, or flat feet.**

## Part IV - - Limited and Non-Covered Services

11. **Hot and cold pack therapy** provided by a physician, including chiropractors, or other licensed providers.
12. **Hypnotism, Hypnotherapy, Hypnotic Anesthesia, and Sleep Therapy** (except for central or obstructive apnea when approved by the Plan).
13. **Lifestyle Improvement Services**, such as physical fitness programs, health or weight loss clubs or clinics.
14. **Medical nutrition therapy** for diabetic care does NOT include food items or nonprescription drugs.
15. **Private Duty Nursing**, except as specifically covered elsewhere.
16. **Private Facility Rooms. Costs** above the semi-private room rate of the institution, except as specifically covered elsewhere.
17. **Organ Transplant:** (*NOTE: Organ transplants are not covered for Small Employer Group Basic Plan Members*)
  - a. expenses related to transplants of animal organs.
  - b. artificial organs, any transplant or transplant services not included (see Part III, Section D).
  - c. expenses incurred by a Member as a donor, unless the recipient is also a Member and these services are not covered under another group health plan or coverage arrangement.
  - d. Costs related to locating and/or screening organ donors.
18. **Temporomandibular Joint (TMJ) Dysfunction. Diagnosis and Treatment for TMJ, Pain Syndrome or Hospitalization for Extraction of Teeth.**
19. **Radial Keratotomy, Myopic Keratomileusis, and any Surgery Involving Corneal Tissue** for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
20. **Sexual Dysfunction.** Treatment of sexual dysfunction (organic or non-organic in nature), including prescription medications.
21. **Sexual Re-assignment**, including, but not limited to, surgery.
22. **Skin Tags and Warts.** Removal of Skin Tags and Warts.
23. **Vision Exams (routine), Refractive Errors of the Eye, Purchase, Examination, or Fitting of Eyeglasses or Contact Lenses**, except as specifically covered elsewhere.

### C. Medical/Mental Health Services That Are Not Covered

Medical/Mental Health Services, unless otherwise covered as a biologically based mental illness, relating to:

1. Autistic disease of childhood;
2. Learning disabilities;
3. Behavioral problems;
4. Mental retardation;
5. Services related to environmental change;
6. Behavioral therapy, modification, or training;
7. Milieu therapy;
8. Sensitivity training;
9. Eating Disorders; and
10. Conduct Disorder.

### D. Reproductive Health Care Services That Are Not Covered

1. **Sterilizations of Dependent Children.**
2. **The following Health Care Services Relating to the Treatment of Infertility:**
  - a. artificial means of conception:
    - i. artificial insemination;
    - ii. in-vitro fertilization;
    - iii. ovum or embryo placement or transfer;
    - iv. gamete intra-fallopian tube transfer;
    - v. cryogenic or other preservation techniques used in such or similar procedures;
    - vi. infertility medication; and
    - vii. any other services or supplies related to artificial means of conception.
  - b. reversals of prior sterilization procedures.
  - c. expenses related to surrogate parenting.
3. **Reproductive Health Care Services**, the coverage of which is prohibited by the laws of this State.
4. **Elective Abortion Services.**
5. **Maternity Care of dependent children**, except for complications of pregnancy which is covered as any other illness.

### E. Medications/Drugs That Are Not Covered

1. **Items Not Previously Mentioned and Not Supplied Under a Supplemental Pharmacy Rider.**
2. **All Over-the-Counter items including but not limited to medications, equipment and supplies.**
3. **Outpatient Drugs Dispensed in a Provider's Office or Non-Retail Pharmacy Location.**
4. **Orthomolecular Therapy**, including nutrients, vitamins (including but not limited to prenatal vitamins), food supplements and baby formula.
5. **Whole Blood and Blood Components Not Classified as Drugs** in the *United States Pharmacopoeia*.
6. **Experimental or Investigational Drugs or Drug Usage** if not recognized by the Food and Drug Administration.
7. **B-12 Injections**, except for pernicious anemia.
8. **Growth Hormone** (except as covered in a supplemental prescription drug rider).
9. **Acne Medication** for Members over age thirty-five (35).

### F. Other Related Services That Are Not Covered

1. **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.
2. **Wigs, Cranial Protheses or Hair Transplants.**

## Part IV - - Limited and Non-Covered Services

3. **Purchase, Examination, Testing or Fitting of Hearing Aids, Tinnitus Maskers, and Supplies.**
4. **Durable Medical Equipment Required for Therapeutic Purposes** in the Member's home (including, but not limited to exercise equipment, cervical pillow or cervical traction). Limitations per policy guidelines apply.
5. **Over-the-Counter Supplies.**
6. **Orthotics, Artificial Aids, Corrective Appliances** (including but not limited to orthotic shoes, braces, crutches, and other supportive devices, or prosthetic devices), except as specifically covered above.
7. **Articles to assist in activity of daily living** (including but not limited to shower chair, high rise, commodes, education on self-care or home management).
8. **Personal Hygiene and Convenience Items** such as, but not limited to, air conditioners, humidifiers, physical fitness equipment, hot tubs, whirlpools and air cleaners.
9. **Dental Services** not specifically listed as a Covered Service, including dental x-rays, appliances, shortening of the mandible or maxillae for cosmetic purposes, or eating and chewing mishaps.
10. **Dental Services and Supplies Related to Ridge Augmentation, Implantology, and Preventive Vestibuloplasty.**
11. **Outpatient rehabilitative therapy for chronic and/or recurring symptoms** including but not limited to arthritis, back pain, and fibromyalgia.

### G. Pre-Existing Conditions

Health Care Services for Pre-Existing Conditions are excluded for a period of *one (1) year (eighteen (18) months for late Members)* following the effective date of coverage or the first day of a waiting period if one applies. The *one (1) year* period shall be reduced by the aggregate number of days that a Member was covered under Creditable Coverage. This Pre-Existing Condition exclusion does not apply to newborn children or children placed for adoption, or adopted children under eighteen (18) provided that the child as of the last day of the *thirty (30) day* period beginning with the date of birth, adoption or placement for adoption is covered under Creditable Coverage and that there has been no significant break in the Creditable Coverage. The Plan will not count days of Creditable Coverage that occur before a significant break in coverage. A significant break in coverage is a period of *sixty-three (63) consecutive days* during all of which a Member does not have any Creditable Coverage, excluding any waiting periods and affiliation periods. Periods of Creditable Coverage shall be counted without regard to the specific benefits covered during the period.

Members shall have the right to provide the Plan with evidence of prior Creditable Coverage, including the right to secure a Certificate of Creditable Coverage from a prior health benefit plan or an insurer and have the Plan assist in obtaining such a certificate. Prior to imposing a Pre-Existing Condition exclusion, the Plan shall inform the Member in writing of its determination of any Pre-Existing Condition

exclusion period that applies and the basis for the determination; provide an opportunity for the Member to submit additional materials regarding prior Creditable Coverage; provide an explanation of any appeals procedures; and provide a reasonable opportunity to submit additional evidence of Creditable Coverage.

### H. Services Covered by Other Payors

1. Health Care Services for injury or sickness, which are job, employment or work related or for which benefits are provided or payable under any Worker's Compensation or Occupational Disease Act or Law; or for which coverage was available under any Worker Compensation or Occupational Disease Act or Law, regardless of whether such coverage was actually applied for.

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 provided or payable under any Workers' Compensation or Occupational Disease Act or Law, are excluded from coverage by the Plan. However, if benefits are paid by the Plan and it is determined that Member is eligible to receive Workers' Compensation for the same incident, the Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Member will consent to reimburse the Plan the full amount of the Reasonable Costs when entering into any settlement and compromise agreement, or at any Workers' Compensation Division Hearing. The plan reserves its right to recover against Member even though:

- (i) The Worker's Compensation benefits are in dispute or are made by means of settlement or compromise; or
- (ii) No final determination is made that the injury or sickness was sustained in the course of or resulted from employment;
- (iii) The amount of Workers' Compensation for medical or health care is not agreed upon or defined by Member or the Workers' Compensation carrier; or
- (iv) The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.

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

2. Health Care Services received directly from Providers employed by or directly under contract with the Member's employer, mutual benefit association, labor union, trust, or any similar person or group.
3. Health Care Services for injury of 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, the Plan may exercise its Rights of Subrogation.

## Part IV - - Limited and Non-Covered Services

4. Health Care Services for conditions that under the laws of this State must be provided in a governmental institution.
5. Health Care Services covered by any governmental health benefit program such as Medicare, Medicaid, ESRD and Tri-Care, unless applicable law requires the Plan to provide primary coverage for the same.

### **I. Services and Payments That Are the Responsibility of Member**

1. Out-of-pocket costs, including Copays, Deductibles, and Coinsurance are the responsibility of the Member in accordance with the attached Summary of Plan Benefits. Additionally, the Member is responsible to a Provider for payment for Non-Covered Services.
2. Finance charges, charges for missed appointments and other administrative charges.
3. Services for which a Member is not legally, or as customary practice, required to pay in the absence of a group health plan or other coverage arrangement.

### **J. Special Situations Affecting Coverage**

If the provision or approval of Covered Services is delayed or becomes impractical due to:

1. Complete or partial destruction of the Plan's facilities;
2. War;
3. Riot;
4. Civil insurrection;
5. Major disaster;
6. Disability of a significant portion of the Participating Providers;
7. Epidemic; or
8. A labor dispute not involving the Plan Participating Providers, the Plan will use its best efforts to arrange for the provision of Covered Services within the limitations of available facilities and personnel.

However, neither the Plan, nor any Participating Provider, shall have any liability or obligation because of a delay or failure to provide such services under the circumstances enumerated above.

If provision or approval of Covered Services under this Contract is delayed due to a labor dispute involving the Plan or Participating Providers, Non-Emergency Care may be deferred until after resolution of the labor dispute.

## Part V - - How Services Are Paid For By The Plan

### A. The Process for Reimbursement of Charges by Participating Providers

When a Member receives Covered Services from a Participating Provider, the Plan will pay the Participating 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 Provider, at the time of service, any Copay or Deductible which is required for that service.

1. **Time Limits.** Participating Providers must file claims to the Plan within *one hundred twenty (120)* days after the date that the cost was incurred. If Member fails to show his/her Plan ID card at the time of service and provider consequently bills the wrong Plan, then Member may be responsible for payment of claim after provider's timely filing period of 120 days has expired.

In any event, the written proof required must be given to the Plan no later than *one hundred twenty (120)* days from the time stated, unless the claimant was legally incapacitated.

2. **Legal Action for Reimbursement: Time Limitations.** No legal action may be brought to recover under this provision within *sixty (60)* days after the claim has been given as required by this contract. No action to recover Member expenses may be brought after *three (3)* years from the time the claim is required to be given.

### B. The Process for Reimbursement of Charges by Non-Participating Providers

1. **Written Notice of Claim.** The Member must give the Plan written notice of the costs to be reimbursed within *three hundred and sixty five (365)* days after the costs were incurred, or as soon as reasonably possible thereafter. The notice must be sent to the Plan or the Plan's agent, and must include:
  - a. name of the Subscriber;
  - b. group contract number; and
  - c. nature of the cost incurred.
2. Claim forms are available from the Plan's Member Services Department to aid in this process **Physical Examination or Autopsy.** The Plan, at its expense, has the right to have the Member examined as often as reasonably necessary while a claim is pending. The Plan may also have an autopsy made, at its expense, unless not allowed by law.
3. **Time Limits.** Claims must be given to the Plan within *three hundred and sixty five (365)* days after the date that the cost was incurred.
4. **Time of Payment of Claim.** The payment for reimbursement of the Member's costs will be made within *thirty (30)* days of when the 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 Plan guidelines, the Plan will arrange for direct payment to either the Non-Participating Provider or the Member, per plan policy. If the Provider refuses direct payment, the Member will be reimbursed for the reasonable costs of the services in accordance

with the terms of this contract. The Member will be responsible for any expenses that exceed Reasonable Costs, as well as any Copay, Deductible, or Coinsurance which is required for the Covered Service.

5. **Legal Action for Reimbursement: Time Limitations.** No legal action may be brought to recover under this provision within *sixty (60)* days after the claim has been given as required by this contract. No action to recover Member expenses may be brought after *three (3)* years from the time the claim is required to be given.

## **Part VI - - Problem Resolution**

### **A. Member Complaints**

The “Policy on Member Complaints and Grievances” which is attached to and made a part of this contract, describes how Member problems or complaints are to be handled.

### **B. Arbitration**

If any dispute arises between the Group and the Plan regarding the terms of this Contract or the operation of the Plan, or between any Member or the Group and any Participating Provider regarding Health Care Services provided to any Member, the dispute may be settled through arbitration, at the Member’s option, in accordance with the rules of the American Arbitration Association or such other rules as may be mutually agreed upon, to the extent not prohibited by law.

## Part VII - - How Coverage Ends

### A. Termination by the Subscriber

In accordance with your employer's Human Resources Policy, you may be allowed to terminate coverage for you and/or any Dependent(s) at any time. The 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.

### B. Termination of Member Coverage

The Plan may terminate, cancel, or refuse to renew a Member's coverage for any of the reasons listed below. Such action by the Plan is called "Disenrollment" of the Member.

1. **Nonpayment of Charges when due.** Failure to make any required Service Charge payments, Copays, Deductibles, or Coinsurance when due. A grace period of *thirty-one (31)* days, unless stated otherwise in this Policy, 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.
2. **Move Outside the Area.** A Member establishes permanent residence outside the Service Area.
3. **Contract Termination.** This contract terminates.
4. **Eligibility.** The Member is no longer eligible for coverage under this contract.
5. **Fraudulent Information.** A Member's application form contains false information or misrepresentation.
6. **Use of ID Card by Another.** A Member allows another individual to use his or her ID Card to obtain services.
7. **Noncompliance with treatment plan.** Unreasonable refusal of the Member to follow a prescribed course of treatment.

A Member may not be disenrolled due to the status of the Member's health or because the Member has exercised her or his rights under the Plan's Policy on Member Complaints and Grievances or the Policy on Appeal Procedures for Medical Review Determinations.

### C. Plan Notice to Group of Termination of Coverage

The Plan will notify the Group of the termination of coverage for any Member. The Plan or Group will then give written notice of the termination to the Members, at least *ten (10)* days prior to the effective date of termination of coverage. 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.

#### Notice of Cancellation

**The notice will set forth at least the following:**

1. The effective date and hour of termination or of the decision to not renew coverage;
2. The reason(s) for the termination or nonrenewal; and
3. The Member's options listed below, including requirements for qualification and how to exercise the Member's rights:
  - a. the right to appeal the termination or nonrenewal through the Plan's Policy on Member Complaints and Grievances;

- b. the availability of Continuation or Conversion of Coverage, if any; and
- c. 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.

### D. Member Appeal of Termination

A Member may appeal the Plan's decision to terminate, cancel, or refuse to renew the Member's coverage. The appeal will be considered to be a Member grievance and the Plan's Policy on Member Complaints and Grievances will govern the appeal procedure.

Pending the appeal decision, coverage will terminate on the date which was set by the Plan. However, the Member may continue coverage, if entitled to do so, by complying with the "Continuation of Coverage" provisions, Section VIII. If the Plan decides the appeal 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.

## Part VIII - - Options After Coverage Is Ended

Under this contract, a Member whose coverage has ended may be eligible for one or more of the following options:

1. Conversion from a group to an individual contract; or
2. Continuation of coverage for a limited time.

### A. Conversion of Coverage (Iowa Code 509B.4)

Changing from a group plan to an individual plan is called "Conversion of Coverage." A "Conversion Contract" is an individual Health Care Services plan (in contrast to a group plan) which may be purchased by a Member whose coverage under this Contract is terminated (under certain circumstances) without evidence of insurability, subject to the following:

1. A converted policy shall not be available to an employee or member if termination of insurance under the group policy occurred because of any of the following:
  - a. Termination of employment or termination of membership and the employee or member was not entitled to continuation of group coverage, or failed to elect continuation.
  - b. Failure to make timely payment of required premium after notice.
  - c. Any other reason, if the employee or member was not continuously insured under the group policy, and for similar benefits under any group policy which it replaced, during the entire three (3) months' period immediately preceding the termination.
  - d. The group policy terminated or an employer's or group policyholder's participation terminated, and the insurance is replaced by similar coverage under another group policy within thirty-one days of the date of termination.
2. If proper notice is given as required in Part VII, Section C, written application and the first premium payment for the converted policy shall be made to the insurer not later than thirty-one (31) days after the termination. The converted policy's effective date shall be the day following the termination of insurance under the group policy.
3. The premium for the converted policy shall be determined in accordance with the insurer's table of premium rates applicable to the age and class of risk of each person to be covered under that policy and to the type and amount of insurance provided.
4. The converted policy shall cover the employee or member and dependents who were covered by the group policy on the date of termination of insurance. At the option of the insurer, a separate converted policy may be issued to cover any dependent.
5. The insurer is not required to issue a converted policy covering any person if the person is or is eligible to be covered by Medicare. The insurer is not required to issue a converted policy covering any person if both paragraphs "a" and "b" below apply:
  - a. If any of the following apply:
    - (1) The person is covered for similar benefits by another individual policy.
    - (2) The person is or is eligible to be covered for similar benefits under any arrangement of coverage for individuals in an employer group, whether insured or uninsured.
  - (3) The person is or is eligible to be covered for similar benefits under any other state or federal law.
6. The benefits provided under sources of the kind referred to in paragraph "a", subparagraph (1), for the person, or the benefits provided or available under sources of the kind referred to in paragraph "a", subparagraphs (2) and (3), for the person, together with the converted policy's benefits, would result in overinsurance according to the insurer's standards for overinsurance.
6. A converted policy may provide that the insurer may at any time request information of a person covered as to whether the person is covered for similar benefits described in subsection 5, paragraph "a", subparagraph (1) or is or is eligible to be covered for similar benefits described in subsection 5, paragraph "a", subparagraphs (2) and (3). The converted policy may provide that as of any premium due date the insurer may refuse to renew the policy or the coverage of any insured person for any of the following reasons:
  - a. Either those similar benefits for which the person is or is eligible to be covered, together with the converted policy's benefits, would result in overinsurance according to the insurer's standards for overinsurance, or the policyholder of the converted policy fails to provide the requested information.
  - b. Fraud or material misrepresentation in applying for any benefits under the converted policy.
  - c. Eligibility of the insured person for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.
  - d. Other reasons approved by the commissioner of insurance.
7. An insurer is not required to issue a converted policy providing benefits in excess of the accident and health insurance under the group policy from which conversion is made.
8. The converted policy shall not exclude, as a preexisting condition, any condition covered by the group policy. However, the converted policy may provide for a reduction of its accident and health benefits by the amount of the benefits payable under the group policy after the individual's insurance terminates under the group policy. The converted policy may also provide that during the first policy year, the benefits payable under the converted policy, together with the benefits payable under the group policy after its termination, shall not exceed those that would have been payable had the individual's insurance under the group policy remained in force and effect.
9. Subject to the other provisions of this Section, if the group insurance policy from which conversion is made insures

## Part VIII - - Options After Coverage Is Ended

the employee or member for basic hospital and surgical insurance, the employee or member may exercise the option of obtaining a converted policy providing coverage on an expense- incurred basis following state mandated Plans.

10. Subject to the other provisions and conditions of this Section, if the group policy from which conversion is made insures the employee or member for major medical expense insurance, the employee or member may obtain a converted policy providing catastrophic or major medical coverage under a plan meeting state mandated requirements.
11. If, under this Section, coverage would be continued under the group policy on an employee or member following termination due to retirement prior to the time the employee or member is or could be covered by Medicare, the employee or member may elect, in lieu of continuation of group insurance, and notwithstanding subsection 1, paragraph "a" above, to have the same conversion rights as would apply if a continued policy were terminated at that time.
12. The converted policy may provide for reduction or termination of coverage of a person upon eligibility for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy.
13. Subject to any preceding conditions, conversion privileges are available to a surviving spouse at the death of the employee or member, with respect to the spouse and children whose coverage under the group policy terminates by reason of the death, or to each surviving child whose coverage under the group policy terminates by reason of death, or when continuation of dependent's coverage is accepted following the employee's or member's death, at the end of the continuation. Subject to any preceding conditions, the conversion privilege is available to the spouse of the employee or member upon termination of coverage of the spouse, by reason of dissolution or annulment of marriage or otherwise ceasing to be a qualified family member under the group policy, while the employee or member remains insured under the policy, or when continuation of dependent's coverage is elected following the dissolution or annulment of marriage, at the end of continuation. This conversion privilege includes children whose coverage under the group policy terminates at the same time. Subject to any preceding conditions, the conversion privilege is also available to a child solely with respect to the child upon termination of coverage by reason of ceasing to be a qualified family member under the group policy, if a conversion privilege is not otherwise provided within this section.
14. If the benefit levels in subsections 9 and 10 exceed the benefit levels provided under the group policy, the converted policy may offer benefits which are

substantially similar to those provided under the group policy in lieu of those in subsections 9 and 10.

15. The insurer may elect to provide group insurance coverage in lieu of the issuance of a converted individual policy. The Conversion Contract may require Copays and Deductibles and premiums that differ from the group contract.

### B. Federal Continuation of Coverage Provisions ("COBRA")

#### 1. Federal Continuation of Coverage Provisions ("COBRA") for employer groups with *twenty (20)* or more employees.

**COBRA (Consolidated Omnibus Budget Reconciliation Act of 1986 and Any Amendments Thereto).** COBRA is a federal law which permits Members to continue coverage under an employer group health plan under certain circumstances. This law applies to employers of *twenty (20)* or more employees, not directly to the Plan. That is, if the Group, as an employer, changes from the Plan to another health plan, insurance carrier or third party administrator (in the case of self-funded arrangement), the right to continuation under federal law is a Subscriber right which transfers to the new carrier or to claims adjudication under the new administrator.

Subscribers need to be aware that they have COBRA rights. This section does not set forth those rights but is intended merely as information and is not to be construed as a binding contractual obligation of the Plan.

In general, Subscribers and their covered Dependents have a right to continue group health coverage if they lose coverage because of a qualifying event. Qualifying events include death of the Subscriber, termination of the Subscriber's employment, a reduction in the Subscriber's hours, divorce or legal separation, a Dependent Child reaching the limiting age under the Plan, the Subscriber's entitlement to Medicare, and other events specified in the federal law. Continued coverage applies to any child born to, or placed for adoption with, the Subscriber after a qualifying event has occurred, provided that the child is added within the appropriate time frames set forth in this contract.

In the case of divorce, legal separation or cessation of dependent status, covered employees and qualified beneficiaries are responsible for notifying the plan administrator within 60 days after the qualifying event or the date on which coverage would be lost due to the event, *whichever is later*. If the employee or qualified beneficiary does not provide notice within the 60 day time frame, then COBRA coverage does not have to be offered.

Subscribers and their covered Dependents generally have a right to continue coverage for *eighteen (18)* months from the date of the qualifying event if the qualifying event is termination of the Subscriber's employment or a reduction in work hours. In the case of individuals who are disabled within the meaning of the *Social Security Act*, special rules may apply to extend coverage of an additional 11 months. For all other qualifying events, coverage shall continue for *thirty-six (36)* months from the date of the qualifying event. However, the right to continue group

## Part VIII - - Options After Coverage Is Ended

coverage ceases upon the happening of certain events specified in the law, such as becoming eligible for Medicare, the employer ceasing to offer group coverage, the employer failing to pay Service Charges timely, becoming covered under other coverage in which there is no limitation on coverage due to prior health conditions other than an exclusion or limitation which does not apply to the qualified beneficiary by reason of Chapter 100 of the Internal Revenue Code of 1986, Title I, Part 7 of the Employee Retirement Income Security Act of 1974 or Title XXVII of the Public Health Services Act, or in the case of a qualified beneficiary who is disabled during the first *sixty (60)* days of continuation coverage, the month that begins more than *thirty (30)* days after the date of final determination that the qualified beneficiary is no longer disabled for Social Security purposes. If the other coverage contains an exclusion, coverage will be continued until the exclusion is satisfied or coverage is otherwise terminated.

It is the Group's responsibility to inform Subscribers of whom to notify when a qualifying event has occurred and to furnish the Subscriber with a COBRA Notification Form. The Plan has agreed with the Group to undertake only limited duties with respect to COBRA as set forth below.

- a. **Payment of Service Charges:** Upon receipt of the COBRA Notification Form, the Plan will send the Subscriber or Dependent who qualifies for COBRA continuation of benefits a notice of the amount of dues needed for the continued benefits. A period of *forty-five (45)* days is allowed in which to pay the initial required subscription fees. The first Service Charge payment will be for a period commencing with the date following the date coverage would otherwise terminate. The Service Charges may be higher than for actively employed Subscribers, as permitted by law.

Subsequent Service Charge payments will be allowed a *thirty (30)* day grace period after the due date. The Plan will bill the Member directly and payment will be made directly to the Plan.

- b. **Enrollment and Benefit Changes:**
- i. if the Group changes benefits, the COBRA Subscriber's benefits will also change to match the Group's new benefit package.
  - ii. the COBRA Subscriber has the same right to change benefit programs as the active Group Members. A Pre-Existing Condition waiting period may not be applied to a transferring Subscriber and his or her covered Dependents.
  - iii. if the Group changes plans or insurers during the period of Continued Group Benefits, the COBRA Subscribers for the Group will be canceled as to coverage under this Contract and become the responsibility of the new health plan or insurer.
- c. **Conversion Privilege:** Subscribers who complete the continuance of benefits period are eligible for a conversion contract offered by the Plan, at the conversion contract rates then in effect. This conversion is only applicable to Subscribers whose Group offers health coverage through the Plan at the conversion contracts rates then in effect.

This conversion is applicable only to subscribers whose group offers health insurance with the Plan at the time the Subscriber's eligibility under the state law ends.

2. **Continuation of Coverage Provisions for employer groups with less than *twenty (20)* employees.**

*Continuation right* refers to the right under Iowa Code chapter 509B and Iowa Administrative Rule 191-29 of an employee or member or the employee's or member's spouse and dependent children whose coverage under a group accident and health insurance policy would terminate because of termination of employment or membership or dissolution or annulment of marriage or death of the employee or member to continue their group insurance coverage under the Plan, **excluding dental care, vision care, and prescription drug coverage.** To be eligible, Members must have been covered by the Plan for at least three (3) months prior to the event that results in loss of coverage. Members who are eligible for or covered under Medicare or become covered under another group insurance plan after the qualifying event, are not eligible for continuation coverage.

This law applies to employers of *twenty (20)* or fewer employees, not directly to the Plan. That is, if the Group, as an employer, changes from the Plan to another health plan, insurance carrier or third party administrator (in the case of self-funded arrangement), the right to continuation under state law is a Subscriber right which transfers to the new carrier or to claims adjudication under the new administrator.

Subscribers need to be aware that they have rights to continue coverage. This section does not set forth those rights but is intended merely as information and is not to be construed as a binding contractual obligation of the Plan.

In general, Subscribers and their covered Dependents have a right to continue group health coverage if they lose coverage because of a qualifying event. Qualifying events include death of the Subscriber, termination of the Subscriber's employment (other than for gross misconduct), a reduction in the Subscriber's hours, divorce or legal separation, a Dependent Child reaching the limiting age under the Plan, the Subscriber's entitlement to Medicare, and other events specified in Iowa law. Continued coverage applies to any child born to, or placed for adoption with, the Subscriber after a qualifying event has occurred, provided that the child is added within the appropriate time frames set forth in this contract.

### **Qualifying events for continuation rights *does not* include:**

- a. A dependent child ceasing to be a dependent of its parent or legal guardian.
- b. Loss of continuation rights under COBRA, Iowa Chapter 509B, or any other state group health insurance continuation law.
- c. Multiple qualifying events shall not be recognized under Iowa Chapter 509B.
- d. Voluntary termination of membership in an association.

Subscribers and their Covered Dependents generally have a right to continue coverage for *nine (9)* months from the date of the qualifying event. However, the right to continue group coverage ceases upon the happening of certain events specified in the law, such as becoming eligible for Medicare, the

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employer ceasing to offer group coverage, the employer failing to pay Service Charges timely, or becoming covered under other coverage in which there is no limitation on coverage due to prior health conditions other than an exclusion or limitation which does not apply to the qualified beneficiary by reason of Chapter 100 of the Internal Revenue Code of 1986, Title I, Part 7 of the Employee Retirement Income Security Act of 1974 or Title XXVII of the Public Health Services Act.

### Notice regarding continuation rights.

- a. An employer or group policyholder must provide written notice of the continuation right arising by virtue of termination of employment or membership, no later than *ten (10)* days after termination.
- b. The employee or member shall make an election regarding continuation of coverage in writing within *ten (10)* days of the later of the date the insurance coverage would cease by virtue of termination of employment or membership, or the date the employer provided written notice of the continuation right.
- c. The Member shall pay the premiums for the continuation coverage within *thirty-one (31)* days of the date the group insurance would otherwise terminate. Payment by the employee or member shall be made in advance of coverage commencing.
- d. An employer or group policyholder need only give written notice of termination of continuation coverage by reason of nonpayment of premium by the employee or member once, in advance, to the employee or member in some general form such as the certificate of coverage.
- e. In the event of a right to continuation coverage arising because of dissolution or annulment of marriage or death of the employee or member, the person eligible for continuation, who shall be the spouse or the custodial parent or legal guardian on behalf of a dependent child, must notify the employer or group policyholder of the occurrence of the event within *thirty (30)* days after the dissolution or annulment of marriage or death of the employee or member. Within *ten (10)* days of receipt of that notice, the employer or group policyholder shall give the person notice of the continuation right, and that person shall have *ten (10)* days from the date the latter notice is received to elect continuation coverage in writing from the employer or group policyholder.
- f. An election to continue coverage received by an employer or group policyholder from an employee or member or other eligible person shall be promptly transmitted to the Plan.

The Plan has agreed with the Group to undertake only limited duties with respect to Continuation of Coverage as set forth below.

- a. **Payment of Service Charges:** Upon receipt of the Continuation of Coverage Declaration Form, the Plan will send the Subscriber or Dependent who qualifies for Continuation of Coverage a notice of the amount of dues needed for the continued benefits. A period of *thirty-one(31)* days is allowed in which to pay the initial required subscription fees. The first Service Charge payment will be for a period commencing with the date following the date coverage would otherwise terminate. The Service Charges

will not exceed the group rate or the actual cost of coverage to the employer for actively employed Members. The coverage provided will be substantially the same as that provided when the Member lost coverage.

Subsequent Service Charge payments will be allowed a *thirty (30)* day grace period after the due date. The Plan will bill the Member directly and payment will be made directly to the Plan.

### b. Enrollment and Benefit Changes:

- i. if the Group changes benefits, the Subscriber's benefits will also change to match the Group's new benefit package.
- ii. the Subscriber has the same right to change benefit programs as the active Group Members. A Pre-Existing Condition waiting period may not be applied to a transferring Subscriber and his or her covered Dependents.
- iii. if the Group changes plans or insurers during the period of Continued Group Benefits, the Subscribers for the Group will be canceled as to coverage under this Contract and become the responsibility of the new health plan or insurer.

- c. **Conversion Privilege:** Subscribers who complete the continuation of benefits period are eligible for a conversion contract offered by the Plan, at the conversion contract rates then in effect. Conversion from group to individual coverage will be allowed without proof of insurability, except in the following cases:

- The Member lost group coverage because of failure to pay premiums;
- The Member was not entitled to or did not request continued coverage;
- The Group policy was terminated and replaced by a similar policy within 31 days;
- The Member was not covered by the group policy for at least *ninety (90)* days prior to the loss of coverage; or
- The Member is eligible or entitled to Medicare or is eligible for or entitled to coverage under a group policy that provides similar benefits under state or federal law.

This conversion is only applicable to Subscribers whose Group offers health coverage through the Plan at the conversion contracts rates then in effect. This conversion is applicable only to subscribers whose group offers health insurance with the Plan at the time the Subscriber's eligibility under the state law ends.

## Part IX - - Coordination of Benefits

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"):

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

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

### A. Applicability

1. This Coordination of Benefits (COB) provision applies to this Plan when a Group Member or the Group Member's covered Dependent has health care coverage under more than one Plan. "Plan" and "this Plan" are defined below.
2. 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:
  - a. shall not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another plan; but
  - b. 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."

### B. Definitions (for COB Purposes Only)

1. "Plan" is any of the following which provides benefits or services for, or because of, medical or dental care or treatment:
  - a. Group insurance or group-type coverage, whether insured or uninsured. This includes prepayment, group practice or individual practice coverage. It also includes medical benefits coverage in group, group-type, and individual automobile "no-fault" and traditional automobile "fault" type contracts.
  - b. "Plan" may include coverage under a governmental plan, or coverage required or provided by law. This does not include a state plan under Medicaid (Title MX, Grants to States for Medical Assistance Programs, of the United States Social Security Act (42 U.S.C.A. 301, et seq.), as amended from time to time).

Each contract or other arrangement for coverage under (a) or (b) is a separate plan. 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.

2. "This Plan" refers to this certificate, which provides benefits for health care expenses.
3. "Primary Plan/Secondary Plan": The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another plan covering the Member and covered Dependents.

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.

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.

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.

4. "Allowable Expense" means a necessary, reasonable and customary health care service or expense including deductibles, coinsurance, or copays, that is covered in full or in part by one or more plans covering the person for whom the claim is made. 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 (unless the patient's stay in a private hospital room is medically necessary either in terms of generally accepted medical practice, or as specifically defined by the Plan) is not an allowable expense;
  - b. If a person is covered by two or more plans that compute the benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fee for a specified benefit is not an allowable expense;
  - c. If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, 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 usual and customary fees 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, precertification of admissions or because the person has a lower benefit because the person did not use a preferred provider.
1. "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.
2. "Claim Determination Period" means a calendar year over which allowable expenses are compared with total benefits payable in the absence of COB to determine if overinsurance exists. However, it does not include any part of a year during which a person has no coverage under this Plan, or any part of a

## Part IX - - Coordination of Benefits

year before the date this COB provision or similar provision takes effect.

3. **“Closed Panel Plan”** is a plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the plan, and that limits or excludes benefits for services provided by other providers, except in cases of emergency or Plan authorized referral by a Participating Provider.
4. **“Custodial Parent”** means a parents 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.

### C. Order of Benefit Determination Rules

1. **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. A plan that does not contain a COB provision that is consistent with this regulation is always primary. The exception is coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contact holder. For example, major medical coverage that is superimposed over base plan hospital and surgical benefits, and insurance type coverage that is written in connection with a closed panel plan to provide Out of Network benefits
    - c. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
  2. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:
    - a. **Non-Dependent/Dependent.** The plan which covers the person as a 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:
      - i. secondary to the Plan covering the person as a Dependent; and
      - ii. primary to the Plan covering the person as other than a Dependent, for example a retired 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.
    - b. **Child Covered Under More Than One Plan.** The order of benefits when a child is covered by more than one plan is:
      - i. The 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 note 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.

- ii. 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 parents 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.
- iii. 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.

- c. **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 2(a) above.
- d. **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:
  - i. primary, the benefits of a plan covering the person as a Group Member, Member or subscriber (or as that person’s dependent);
  - ii. secondary, the benefits under the continuation coverage. above rules determines the order of benefits, the benefits of the plan which covered a Group Member, Member or subscriber longer is primary.
- e. 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.

### 3. Effect of COB on the Benefits of this Plan.

- a. **When This Section Applies.** This section applies when, in accordance with Section C “Order of Benefit Determination Rules,” 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.
- b. **Reduction in this Plan’s Benefits.** The benefits of this Plan will be reduced when the sum of:
  - i. the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
  - ii. 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.

## Part IX - - Coordination of Benefits

- iii. If a covered person 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.

4. **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.

5. **Facility of Payment.** A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which 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.

6. **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:
  - a. the persons it has paid or for whom it has paid;
  - b. insurance companies; or
  - c. other organizations.

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

### D. Calculation of Benefit's, 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.

### E. Coordination of Benefits With Medicare

Medicare Benefits provisions apply when a covered person has health coverage under the Plan and is eligible for insurance under Medicare, Parts A and B, (whether or not the covered person has applied or is enrolled in Medicare). This provision applies before any other Coordination of Benefits Provision of the Plan.

### F. Members with End Stage Renal Disease (ESRD)

1. The Plan has primary responsibility for the claims of a Member:
  - a. Who is eligible for Medicare secondary benefits solely because of ESRD, and;
  - b. During the Medicare coordination period of 30 months, which begins with the earlier of:
    - the month in which a regular course of renal dialysis is initiated, or
    - in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.
2. The plan has secondary responsibility for the claims of a Member:
  - a. Who is eligible for Medicare primary benefits solely because of ESRD, and;
  - b. The Medicare coordination period of 30 months has expired.

## Part X - - Subrogation and Right of Reimbursement

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

If a Member has received or receives a recovery from the third party, the Health Plan has a right to reduce or be reimbursed for benefits it has provided and to be provided to the Member. This is called "Reimbursement" and this part of this contract covers such situations.

The 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 the Plan, this acceptance constitutes the Member's consent to the provisions discussed below.

### A. Plan's Rights of Subrogation

In the event of any payments for benefits provided to a Member under this Contract, the Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member, his parents, heirs, guardians, executors, or other representatives may have against any person or organization. These subrogation and reimbursement rights also include the right to recover from uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, automobile medical payments coverage, premises medical expense coverage, and workers compensation insurance or substitute coverage. The Plan shall be entitled to receive from any such recovery an amount up to the Reasonable Costs Charges for the services provided by the Plan. In providing benefits to a Member, the Plan may obtain discounts from its healthcare 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 the Plan for an illness or injury, the 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 the Plan. The Plan is granted a first priority right to subrogation or reimbursement from any source of recovery. The Plan's first priority right applies whether or not the Member has been made whole by any recovery. The Plan shall have a lien on all funds received by the Member, his parents, heirs, guardians, executors, or other representatives up to the Reasonable Costs Charge for the Health Care Services provided and to be provided to the Member. The Plan may give notice of that lien to any party who may have contributed to the loss.

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

### B. Plan's Right to Reduction and Reimbursement.

The Plan shall have the right to reduce or deny benefits otherwise payable by the Plan or to recover benefits previously paid by the Plan to the extent of any and all payments made to or for a 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.

Any such right of reduction or reimbursement provided to the Plan under this Contract shall not apply or shall be limited to the extent that statutes or the courts of this State eliminate or restrict such rights.

The Plan shall have a lien on all funds received by the Member, his parents, heirs, guardians, executors, or other representatives up to the Usual and Reasonable Charge for the Health Care Services provided and to be provided to the Member.

### C. Member's Responsibilities

The Member, his parents, heirs, guardians, executors, or other representatives must take such action, furnish such information and assistance, and execute such instruments as the Plan may require to facilitate enforcement of its rights under this Part. The Member shall take no action prejudicing the rights and interests of the Plan under this provision. Neither a Member nor his attorney or other representative is authorized to accept subrogation or reimbursement payments on behalf of the Plan, to negotiate or compromise the Plan's subrogation or reimbursement claim, or to release any right of recovery or reimbursement without the Plan's express written consent. Any Member who fails to cooperate in the Plan's administration of this Part shall be responsible for the Reasonable Costs Charges for services subject to this Part and any legal costs incurred by the Plan to enforce its rights under this Part. Failure to comply with this Part will entitle the Plan to withhold benefits, services, payments, or credits due under the Plan.

**ATTACHMENT I**  
**Policy on Member Complaints, Appeal Procedures and Medical Review**

**MEMBER COMPLAINTS AND APPEAL PROCEDURES**

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. Members, health care providers with knowledge of the Member's medical condition, authorized representative of the Member and/or an attorney may appeal any adverse decision by Sanford Health Plan. The following types of denials will be considered for the appeals process.

**Types of Denials:**

1. **Benefits Denial** – a denial that is specifically excluded from the Member's benefits package and is not considered a medical necessity denial.
2. **Medical Necessity Denial** – a denial of care of services that could be considered a covered benefit depending on the circumstances. Examples:
  - a. Experimental Treatments
  - b. Cosmetic procedures
  - c. Pharmaceutical Prior Authorizations
  - d. Access to Out of Network Practitioners and Providers
3. **Claims Denials** – denials based on timely and accurate filing of claims and failure to request authorization of services.

**Types of Appeals:**

**Appeal:** A request to change any previous adverse decision made by Sanford Health Plan. An appeal can be for a pre or post service request.

**Expedited Appeal:** A request to change a previous decision made by Sanford Health Plan for an urgent care request.

**External Appeal:** An external appeal is a request for an independent, external review of the final determination made by Sanford Health Plan through its internal appeals process.

**Complaint:** An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and provider complaints. A process has been established for Members (or their designees) and providers to use when they are dissatisfied with the Plan, its providers, or processes.

**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 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.

Audit trails for complaints, appeals and denials are provided by Amisys and an access database which includes documentation of the complaint and/or appeal by date, service, procedure, and Member reason. The denial file includes documentation

telephone notification, including 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 admission denial and reason for denial. If the Plan indicates certification by use of a number, the number must be called the "authorization number."

**Complaints and Appeals can be made for up to 180 days from denial notification.**

**Complaint and Post-Service Appeal Procedure**

If any Member or authorized representative acting on behalf of the Member, has a question, complaint or other problem regarding claims payment for a post service(s) or those services already received, any aspect of the Plan's services, his or her relationship with the Plan and its providers other than a complaint regarding certification, or authorization decision, the Member or the authorized representative should contact the Plan by calling or sending a written complaint to the following address:

Sanford Health Plan  
PO Box 91110  
Sioux Falls, SD 57109-1110  
Phone: (800) 752-5863 or  
(605) 328-6800

The Plan's goal is to make a decision and notify the Member in writing of its proposed resolution within sixty (60) days of receipt of complaint. If the issue unsatisfactorily resolved the Member will be informed of his or her right to appeal the decision. Member notification of the complaint response will be made in writing or by telephone, which will be logged for reference. Any adverse decision notification will advise the Member of the opportunity to submit written comments, documents or other information related to the appeal. For complaints related to the quality of care, the Plan will, at a minimum, state that the Member's complaint was received and investigated.

If the Member or a Member's authorized representative appeals an adverse complaint response, a thorough investigation of the substance of the appeal including any aspects of clinical care involved will be conducted by an individual designated by the Plan. A person who was not the subordinate of any person involved in the initial determination will review the complaint/post-service appeal.

The Plan will document the substance of the appeal and any actions taken. Full investigation of the substance of the appeal, including any aspects of clinical care involved will be coordinated by the Complaint Coordinator. For medical necessity post-service appeals only, a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review

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the appeal.

If the post-service appeal response is adverse, the Member shall be informed of their additional right to contact the IA Division of Insurance or through a court of law.

Iowa Commissioner of Health  
330 Maple St.  
Des Moines, IA 50139  
Phone: (515) 282-4227

**Prior Authorization (Pre-Service) Appeals**

The Appeals procedure for Prior Authorization or Pre-Service must be followed when there has been a medical necessity denial that is adverse to the Member. This adverse determination does not meet The Plan's requirements for medical necessity, appropriateness of health care setting or level of care, and the requested service is therefore denied or payment is reduced. This type of denial could be in relation to experimental treatments, cosmetic procedures, pharmaceutical coverage or access to Nonparticipating Providers. Two types of initial appeals are available to Members and providers to address concern regarding medical determination and prior authorization or pre-service request decisions: an expedited appeals process and a standard appeals process. An expedited appeals process is used when the condition is an emergency or urgent in nature, as defined by the Policy (Part I).

**Expedited Appeals Process**

An expedited review of prior authorization (pre-service) denial determination not to authorize must be utilized if the Member or practitioner acting on behalf of the Member believes that an expedited determination is warranted. This can be done by oral or written notification to the Plan. The Plan 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.

*Telephonic notification* of the Plan's expedited decision must be provided to the hospital, the attending practitioner, and the Member as expeditiously as the Member's medical condition requires, but *no later than seventy-two (72) hours* from the initial request.

*Written notification* of the Plan's expedited decision must be provided to the hospital, the attending practitioner and the Member with the decision of prior authorization or denial *within two (2) business days*, providing the initial notification was not in writing.

If the expedited review process does not resolve a difference of opinion, the Member or representative may submit a written grievance, unless the provider is prohibited from filing a

grievance by federal or state law. Sanford Health Plan will review this appeal as a standard appeal.

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.

**Standard Appeals Process**

A standard appeal may be requested by a Member, his or her representative or Provider by writing or telephoning the Health Services Department at 1-800-805-7938 or (605) 328-6807 if the medical determination for a request for service was adverse to the Member. The appeals process is included in the Member's initial denial letter.

The attending Practitioner and the Member will be made aware, by phone, of their responsibility for submitting the documentation required for resolution of the appeal if needed. Documentation may include sending copies of part or all of the medical record and/or a written statement from the Practitioner. Only the necessary information that pertains to the case in question will be requested. Documentation of the substance of the pre-service appeal and any actions taken will be recorded. If the decision is adverse, the notification will advise the Member of the opportunity to submit written comments, documents or other information related to the appeal.

Full investigation of the substance of the appeal, including any aspects of clinical care involved will be completed by the at least one Physician advisor (may be from the Medical Management, Quality, or Pharmacy & Therapeutics Committee) representing the same or appropriate specialty who is conversant with the appeal process, whose scope of practice includes the services or treatment being reviewed and who was not involved in the initial determination will review the documentation provided.

Determinations will be made within thirty (30) calendar days of receiving the necessary information to complete a standard appeal.

**Written Decision Process**

The written decision for the Standard (Pre-Service and Post-Service) and Expedited Review (Pre-Service only) must contain the following information:

- Reason for the standard or expedited review decision in an easily understandable language;
- Names, titles, and qualifying credentials of the clinical peer participating in the review process;
- Notification the Member can receive, upon request, reasonable access and copies of all documents relevant to the Member's appeal;
- Reference to the benefit provision, guideline, protocol

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and notification that the Member on request can have copy of actual benefit provisions, guidelines, and protocols;

- Statement of the reviewer's understanding of the Member's grievance and reviewer's decision;
- Reviewer's principal reasons for the decision in sufficient detail for the Member to respond further;
- Instructions for requesting written statement of clinical rationale, including clinical review criteria used to make the decision if applicable;
- If applicable, a statement containing a description of the process to obtain a standard review of a decision and the written procedures governing a standard review, including any required timeframes for review; and a

Description of the next level appeal within the organization and or the right to appeal to an external review organization (for medical necessity denials only) as well as any written procedures as it pertains. Final denial 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.

If the pre-service appeal response is adverse, the Member shall be informed of the additional right to contact the IA Division of Insurance or through a court of law.

Iowa Commissioner of Health  
330 Maple St.  
Des Moines, IA 50139  
Phone: (515) 282-4227

The Member will be provided access to and copies of all documents relevant to their appeal (pre-service, post-service and expedited) and determination by requesting this from the Plan by phone or in writing.

#### **INDEPENDENT, EXTERNAL REVIEW OF FINAL DETERMINATIONS**

**(Iowa Code 514J, IA Rule 191-76):**

##### **A. Notification of right to independent, external review**

For Iowa residents, an independent, external review of their appeal will be re-evaluated through the Iowa Insurance Division. The mechanism for the appeal of a denial of coverage based on medical necessity will follow the examples listed in NCQA Surveyor Guidelines. The Plan's written notification of the Standard Review Determination to the Member will include the following information:

1. Evidence the Member was covered by the Plan at the time the service or treatment was proposed;
2. Evidence the Member has been denied coverage based on a determination by the Plan that the proposed service or

treatment does not meet the definition of medical necessity;

3. Evidence the Member, or the Member's treating health care provider acting on behalf of the Member, has exhausted all internal appeal mechanisms provided under the Plan's evidence of coverage.
4. Notification that the request for an external review must be filed within *sixty (60)* days of receipt of the coverage decision from the Plan.

##### **B. Filing a request for external review**

To have a denied medical claim re-evaluated by an independent, external review agent, the Member, or the Member's treating health care provider acting on behalf of the Member, must file the following request:

1. The request for external review to the insurance commissioner must be filed within *sixty (60)* days of receipt of the Plan's coverage decision.
2. A request made to the Division of Insurance, 330 Maple Street, Des Moines, Iowa 50319;
3. A copy of the Plan's coverage decision must accompany the written request for an external review;
4. A \$25 filing fee is required unless the Member is requesting that the fee be waived. The check should be made payable to the Insurance Division. If a waiver is requested, the request shall include an explanation of why the Member is requesting that the fee be waived.

##### **C. Certification of Request**

The commissioner shall have *two (2)* business days from receipt of a request for an external review to certify the request. The commissioner shall certify the request if all of the following criteria listed in Section A 1-4 in this Independent, External Review Section are satisfied.

The commissioner shall notify the Member, or the Member's treating health care provider acting on behalf of the Member, and the Plan in writing of the certification. The Plan has *three (3)* business days to contest the commissioner's certification decision. If the commissioner finds that the request for external review is not eligible for certification, the commissioner, within *two (2)* business days, shall notify the Member, or the Member's treating health care provider acting on behalf of the Member, in writing of the reasons that the request for external review is not eligible for certification.

If the commissioner finds that the request for external review is eligible for certification, notwithstanding the contest by the Plan, the commissioner shall notify the Plan in writing of the reasons for upholding the certification.

The commissioner shall fax the certification decision to the Plan and the Member, or the Member's treating health care provider acting on behalf of the Member, within the two-day period specified above.

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#### D. The external review process

The external review process shall meet the following criteria:

1. The Plan, within three (3) business days of a receipt of an eligible request for an external review from the commissioner, or within three (3) business days of receipt of the commissioner's denial of the Plan's 's contest of the certification of the request, whichever is later, shall do all of the following:
  - a. Select an independent review entity from the list certified by the commissioner. The independent review entity shall be an expert in the treatment of the medical condition under review. The independent review entity shall not be a subsidiary of, or owned or controlled by, the Plan , or owned or controlled by a trade association of Plans s of which the Plan is a member.
  - b. Notify the Member, and the Member's treating health care provider, of the name, address, and telephone number of the independent review entity and of the Member's and treating health care provider's right to submit additional information.
  - c. Notify the selected independent review entity by facsimile that the Plan has chosen them to do the independent review and provide sufficient descriptive information to identify the type of experts needed to conduct the review.
  - d. Provide to the commissioner by facsimile a copy of the notices sent to the Member and to the selected independent review entity.
2. The independent review entity, within three (3) business days of receipt of the notice, shall select a person to perform the external review and shall provide notice to the Member of a brief description of the person including the reasons the person selected is an expert in the treatment of the medical condition under review. The independent review entity does not need to disclose the name of the person. A copy of the notice shall be sent by facsimile to the commissioner.
3. The Member, or the Member's treating health care provider acting on behalf of the Member, may object to the independent review entity selected by the Plan or to the person selected as the reviewer by the independent review entity by notifying the commissioner and Plan within ten (10) days of the mailing of the notice by the independent review entity. The commissioner shall have two (2) business days from receipt of the objection to consider the reasons set forth in support of the objection to approve or deny the objection, to select an independent review entity if necessary, and to provide notice of the commissioner's decision to the Member, the Member's treating health care provider, and the Plan .
4. The Plan, within fifteen (15)days of the mailing of the notice by the independent review entity, or within three (3) business days of a receipt of notice by the commissioner following an objection by the Member, whichever is later, shall do all of the following:
  - a. Provide to the independent review entity any information submitted to the Plan by the Member or the Member's treating health care provider in support of the request for coverage of a service or treatment under the Plan's 's appeal procedures.
  - b. Provide to the independent review entity any other relevant documents used by the Plan in determining whether the proposed service or treatment should have been provided.
  - c. Provide to the commissioner a confirmation that the information required in paragraphs "a" and "b" has been provided to the independent review entity, including the date the information was provided.
5. The Member, or the Member's treating health care provider, may provide to the independent review entity any information submitted under any internal appeal mechanisms provided under the Plan's 's evidence of coverage, and other newly discovered relevant information. The Member shall have ten (10) business days from the mailing date of the notification of the person selected as the reviewer by the independent review entity to provide this information. The independent review entity may reasonably decide whether to consider any information provided by the Member or the Member's treating health care provider after the ten-day period.
6. The independent review entity shall notify the Member and the Member's treating health care provider of any additional medical information required to conduct the review within five (5) business days of receipt of the documentation required under subsection 4. The Member or the Member's treating health care provider shall provide the requested information to the independent review entity within five (5) days after receipt of the notification requesting additional medical information. The independent review entity may reasonably decide whether to consider any information provided by the Member or the Member's treating health care provider after the five-day period. The independent review entity shall notify the commissioner and the Plan of this request.
7. The independent review entity shall immediately, but not later than thirty (30) days from the date the independent review entity received the information required under subsection 4 from the Plan, notify the Plan Member or Member's treating health care provider, and insurance division of the external appeal decision. The initial notification shall be delivered by telephone or fax transmission, and a hard copy of the notice may be delivered by regular mail. The independent review entity, for good cause, may request an extension of time from the

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commissioner.

8. The confidentiality of any medical records submitted shall be maintained pursuant to applicable state and federal laws.

**D. Expedited review**

The Member's treating health care provider shall directly contact the Plan or organized delivery system for an expedited review if the Member's treating health care provider states that delay would pose an imminent or serious threat to the Member. The Member's treating health care provider and the Plan shall select, within 72 hours, an independent review entity to conduct the external review. In the event that the Member's treating health care provider and the Plan cannot reach an agreement upon the selection of an independent review entity, the Member's treating health care provider shall notify the commissioner who shall select an independent review entity. The Plan and the Member's treating health care provider shall provide any additional medical information to the review entity. In the event the Plan does not find that a delay would pose an imminent or serious threat to the Member, the Member's treating health care provider may ask the commissioner to immediately review the request for certification as an expedited review.

A review by the commissioner shall follow the 72-hour expedited review time period.

**E. Other External Review Provisions**

1. A requirement that all reasonable fees and costs of the independent, external review entity be paid by the carrier or organized delivery system.
2. A provision directing each Plan to file with the Commissioner, an annual report including the number of independent, external reviews requested, the number of external review requests certified by the Commissioner, and the number of coverage decisions upheld by an independent, external review entity.
3. Immunity for an independent, external review entity from liability for damages arising out of a determination, unless the determination is made in bad faith or involves gross negligence.
4. That the standard of review to be used by an independent, external review entity is whether the health care service or treatment denied by the Plan or organized delivery system was medically necessary as evidenced by the Member's Policy, and consistent with clinical standards of medical practice.
5. That the review decision by the independent, external review entity is binding upon the Plan and the organized delivery system and that the findings of fact by the independent, external review entity are conclusive and binding on appeal and in any subsequent proceeding or action involving the same facts. The Member or the Member's treating health care Provider may appeal the independent, external review entity's decision in Polk County District Court or the district court in the county in which

the Member resides. A petition for judicial review must be filed within *fifteen (15)* business days after issuance of the review decision.

6. The Complaint Coordinator will report quarterly to the Plan's Board of Directors and Quality Improvement Committee with regard to the number and nature of reported appeals and their resolutions. The Quality Improvement Committee shall report annually to the Commissioner of Insurance or Health as appropriate, the description of the medical review determinations appeal procedures, those appeals in which adverse determinations are upheld, and those appeals that are not resolved within thirty (30) days.

**Iowa Member Rights**

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

1. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race, color, religious creed, handicap, ancestry, national origin, age, sex or sources of payment for care.
2. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
3. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. Members have the right to select a Primary Care Physician (PCP) of their choice. If
5. Member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
6. 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 Iowa law.
7. Members have the right to know the identity and professional status of individuals providing service to them and to know which physician or other practitioner is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
8. Members have the right to obtain complete and current information concerning diagnosis (to the degree known), treatment, and any known prognosis in a way that is understandable from the Practitioners responsible for coordinating their care. Members also have the right to participate with Practitioners in decision making regarding their treatment planning.
9. Members have the right to give informed consent before the start of any procedure or treatment.

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10. When Members do not speak or understand the predominant language of the community, the Plan will make its best efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
  11. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and easy to read.
  12. 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.
  13. Members have the right to appeal any decision regarding medical necessity made by the Plan and its providers.
  14. Members have the right to disenroll from the Plan.
  15. Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
7. Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating, to the degree possible, in understanding their behavioral health care problems and developing mutually agreed-upon treatment goals.
  8. Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
  9. Members are responsible for notifying the Plan within thirty (30) days at 1-800-752-5863 or (605) 328-6800 if they change their name, address, or telephone number. Also, if Members get married, they must inform us of their change in status.
  10. Members are responsible for notifying their employer of any changes of eligibility that may affect their membership or access to services. The employer is responsible for notifying the Plan.

**Member Responsibilities**

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

1. Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible practitioner. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
2. Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when telephoning or contacting the Plan.
3. Members are responsible for following all access and availability procedures.
4. 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 you must use the nearest emergency facility. State law requires that the ambulance transport you to the hospital of your choice unless that transport puts you at serious risk.
5. Members are responsible for notifying the Plan of an emergency admission as soon as reasonably possible and no later than forty-eight (48) hours after becoming physically or mentally able to give notice.
6. Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible practitioner or the hospital.

**ATTACHMENT II**  
**Service Area**

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

CLAY, DICKINSON, EMMET, LYON, O'BRIAN, OCSEOLA, and SIOUX

**ATTACHMENT III**  
**Summary of Plan Benefits**