

MINNESOTA MEMBER HANDBOOK

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Sanford Health Plan of Minnesota

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ABOUT SANFORD HEALTH PLAN OF MINNESOTA

Welcome to Sanford Health Plan of Minnesota (hereinafter referred to as "The Plan"). We are pleased to have you as a member and look forward to providing you and your enrolled dependents with health care services. The Plan is proud of the fact that we not only manage your health care, but also provide you with an excellent system of medical professionals to meet your health care needs. We offer you comprehensive benefits and a large choice of primary care physicians, specialists, and other ancillary providers.

As a member of the Plan, you are encouraged (but not required) to select a Primary Care Physician (PCP) who will coordinate your health care needs. We also encourage you to make an appointment with your PCP before you become ill and to see your selected PCP as needed, thereby identifying any minor problems before they become major. You owe it to yourself to take an active role in improving and maintaining good health.

Sanford Health Plan of Minnesota benefits are designed as a unique alternative to existing health insurance packages in our region. Applying our expertise in health care administration, quality patient care and network development, we have created a Health Plan with a focus on the health and well being of our members. The Plan's Medical Management Program monitors utilization and coordinates care plans to ensure that our members are receiving the most appropriate care. Also, prevention and wellness programs are built into the benefit package. This encourages members to seek treatment early and to live healthier lifestyles, thereby controlling long-term health care costs.

The key to our success is our network of primary care physicians, specialists and hospitals. In partnership with these health care Practitioner and/or Providers, the Plan actively promotes health care education, prevention and early detection. Together, we understand the need to deliver the best possible patient care, maintaining good community health, while developing cost-effective solutions. Plan members have access to hundreds of area physicians and a hospital network that includes the region's most commendable tertiary care facility – Sanford Hospital. Because high-quality care is a priority, our network of providers are subject to strict credentialing guidelines and performance reviews.

In short, the Plan has been developed to ensure that all members receive the right care, in the right place, at the right time, for the right reason.

This Handbook, along with your Policy, is designed to give you the basic information needed as a member. It will also serve as a reference when seeking health care services. If you have additional questions after reading the Handbook or your Policy or need any assistance, please contact the Member Services Department at (605) 328-6800 or toll free at 1-800-752-5863.

This Member Handbook is not a contract.

For more specific details of your coverage, please refer to your "Policy" which provides all of the terms and conditions of enrollment. **This health care plan may not cover all your health care expenses. Read your Policy carefully to determine which expenses are covered.**

HOW TO CONTACT US

If you have additional questions after reading the Handbook or your Policy or need any assistance, please contact Sanford Health Plan between the hours of 8am to 5pm CST, Monday through Friday. Please call:

- Member Services Department at (605) 328-6800 or toll free at 1-800-752-5863 for information on benefits, enrollment, participating providers and claims.
- Utilization Department at (605) 328-6807 or toll free at 1-800-805-7938 for certifications, prescription drug and formulary information.

MEMBER RIGHTS & RESPONSIBILITIES

A. Minnesota 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 available and accessible services including Emergency services, as defined in the Policy, 24 hours a day and seven days a week;

2. Members have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice;
3. Members have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the Plan and its health care Practitioner and/or Providers, in accordance with existing law;
4. Members have the right to file a complaint with the Plan and the Commissioner of Health and the right to initiate a legal proceeding when experiencing a problem with the Plan or its health care Practitioner and/or Providers;
5. Members have the right to a grace period of 31 days for the payment of each service charge for individual coverage falling due after the first premium during which period coverage shall continue in force;
6. Medicare members have the right to voluntarily disenroll from the Plan and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law;
7. Medicare members have the right to a clear description of nursing home and home care benefits covered by the Plan;
8. 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;
9. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity;
10. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy;
11. Members have the right to select a Primary Care Physician (PCP) of their choice. If a member is dissatisfied for any reason with the PCP initially chosen, they have the right to choose another PCP;
12. 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 Minnesota law;
13. 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 the Plan's clinical guidelines and protocols;
14. 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, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with practitioners in decision making regarding their treatment planning;
15. Members have the right to give informed consent before the start of any procedure or treatment;
16. When a member does 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 who is able to communicate with the member;
17. 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;
18. Members have the right to appeal any decision regarding medical necessity made by the Plan and its Practitioner and/or Providers;
19. Members have the right to disenroll from the Plan;
20. Members have the right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities; and
21. Members have the right to make recommendations regarding the organization's Member Rights and Responsibilities policies.

B. Minnesota 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 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.
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 health care problems, including behavioral 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 if they change their name, address, or telephone number. Also, if members get married, they must inform the Plan 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.

CONFIDENTIALITY AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

Sanford Health Plan of Minnesota receives and maintains a great deal of personal health information about our Members and we protect the privacy of all patient information in accordance with state privacy (MN Statute 144.335) and federal HIPAA regulations.

We will share personal health information of members as necessary to carry out treatment, payment, and health care operations as permitted by law. Prior written authorization will be requested for the release of medical records from a Practitioner and/or Provider for payment or other healthcare operations. 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.

PROTECTION OF ORAL, WRITTEN AND ELECTRONIC INFORMATION ACROSS THE ORGANIZATION

All members of our workforce are required to comply with the provisions of the Plan's workforce policy on *General Obligations Regarding Uses and Disclosures of Personal Health Information*. We consider workforce to include employees (Part time, Full time, and PRN), volunteers, trainees, and other persons whose work performance is under the direct control of Sanford Health Plan of Minnesota, whether or not they are paid by us.

- Personal health information of a member may not be used within Sanford Health Plan of Minnesota for non-health plan functions, unless such use or disclosure is specifically authorized by a signed authorization by the member.
- When using, requesting or disclosing a member's personal health information, all reasonable efforts are made to limit the information used, requested or disclosed to that which is minimally necessary to accomplish the purpose of the use or disclosure in accordance with our *Minimum Necessary Policy*.
- All workforce members must attend required educational and training sessions relating to privacy and confidentiality of personal health information.
- All workforce members must take reasonable steps to safeguard personal health information from any intentional or unintentional use or disclosure that is in violation of this or any other policy of Sanford Health Plan of Minnesota. Such safeguarding includes, but is not limited to, storing personal health information in a cabinet or closed file at the end of the workday; maintaining privacy during oral discussions of personal health information; restricting electronic transmission of personal health information to job related duties; and disposing of documents strictly in accordance with policies of Sanford Health Plan of Minnesota.
- Sanford Health Plan of Minnesota will take appropriate disciplinary measures against workforce members who violate any policy or procedure of Sanford Health Plan of Minnesota concerning the privacy of member information. Discipline for such infractions of our privacy policies and procedures may include reprimand, suspension, or discharge of the responsible workforce member, depending on the severity of the misconduct.

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.

1. **Disclosures for Treatment.** We are authorized to have access to and use personal health information held by any healthcare Practitioner and/or Provider who delivers healthcare services to you for current treatment or medical emergencies.
2. **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. 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.
3. **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.
4. **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 of Minnesota may consider if disclosure of all or part of the information would endanger the member.
5. **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 is available to help you manage your illness better. We will not use your information to communicate with you about products or services which are not health-related without your written permission.
6. **Information Received Pre-enrollment.** We may request and receive from you and your health care Practitioner and/or 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.
7. **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.
8. **Other Uses and Disclosures.** We may release your personal health information for any purpose required by law. For example we may release your personal health information for the following activities: public health investigations, government oversight agencies conducting audits, court ordered subpoenas, and workers compensation agencies.

RIGHTS THAT YOU HAVE

1. **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.
2. **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.

3. **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.
4. **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. 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.

INFORMATION FOR EMPLOYERS

No use or disclosure of personal health information may be made by any applicable person to a plan sponsor (i.e. employer) unless at least one of the following conditions are met:

1. Sanford Health Plan receives a signed certification from the employer that the plan documents restrict the use and disclosure of personal health information as required by the HIPAA regulations on privacy and confidentiality, and that the employer agrees to comply with the restrictions, and the information has been requested by the employer for use in carrying out *plan administrative functions only* (i.e. employers must certify they do not use or disclose the information for employment-related actions and decisions);
2. The information provided to the employer is summary health information, and the employer has requested it for the purpose of obtaining premium quotes, or determining whether to amend, modify or terminate the sponsored health plan (*summary health information* means personal health information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom an employer has provided health benefits under a group health plan, and from which all individual identifiers are eliminated);
3. The information provided to the employer is enrollment or disenrollment information or information on whether individuals are participating in the sponsored plan, and the employer has requested it for the purpose of administering the sponsored plan; or
4. There is a signed authorization by the member or the member's representative which specifically authorizes the use or disclosure. A signed authorization form is required for uses by or disclosures to an employer if the use or disclosure does not meet the conditions described in paragraph 1, 2 or 3 above. Prior to any use by or disclosure to an employer under this paragraph 4, the procedures for obtaining and verifying authorization described in the policy for *Obtaining and Complying With Member Authorizations* must be followed.

If you would like a copy of your *Notice of Privacy Practices*, please call Member Services at (605) 328-6800 or 1-800-752-5863.

IMPORTANT CONSUMER INFORMATION

1. **COVERED SERVICES:** Services provided by the Plan will receive the maximum coverage available if provided by Participating Providers, or authorized by the Plan. Your Policy fully defines what services are covered and describes procedures you must follow to obtain coverage.
2. **PROVIDERS:** Enrolling in the Plan does not guarantee services by a particular provider on the list of providers. When a provider is no longer part of the Plan, you must choose among remaining Participating Providers.
3. **REFERRALS:** All referrals to Non-Participating Providers and certain types of health care providers must be authorized by the Plan in order to receive the maximum coverage available. See your Policy.
4. **EMERGENCY SERVICES:** Emergency services from providers who are not affiliated with the Plan will receive the maximum coverage available only if proper procedures are followed. Your Policy and the Emergency Situations section of this Handbook explain the procedures and benefits associated with emergency care from the Plan and Non-Participating Providers.
5. **URGENT SERVICES:** 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 (if one has been selected) or go to the nearest Participating Provider immediately and follow his or her instructions. A member may always go directly to a participating urgent care or after hours clinic.
6. **EXPERIMENTAL OR INVESTIGATIVE SERVICES:** Means a drug, device, medical treatment, diagnostic procedure, technology or procedure for which reliable evidence does not permit conclusions concerning safety, effectiveness, or effect on health outcomes. Sanford Health Plan of Minnesota makes it's determination of

experimental, investigative, or unproven based on a preponderance of evidence after the examination of the following reliable evidence, none of which shall be determinative in and of itself:

- a. whether there is final approval from the appropriate government regulatory agency, if approval is required;
- b. whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer review journals, or the reports of clinical trial committees and other technology assessment bodies;
- c. whether there are consensus opinions of national and local health care Practitioner and/or Providers in the applicable specialty or subspecialty that typically manages the condition as determined by a survey or poll of a representative sampling of these Practitioner and/or Providers.

Experimental and/or investigative procedures/services are **not covered** and are specifically excluded from coverage in the Member's Policy.

7. **NEW TECHNOLOGY:** In order to ensure members access to safe and effective care, the Plan has adopted a formal mechanism to evaluate and address new developments in medical and behavioral procedures, pharmaceuticals and devices. New technology to be reviewed includes clinical interventions, procedures, pharmacological treatments and devices. The Medical Management Quality Committee is responsible for recognizing and evaluating new health care services, procedures and pharmacological treatments as well as their application for Plan Members. A specialist representing the new technology (i.e. provider, pharmacist, etc.), if not a member of the Committee will be invited to present the technological aspects of the service, procedure, or pharmacological treatment. Published scientific evidence and information from literature and the Internet will be reviewed to make the appropriate decisions. The technology must have final approval from appropriate government regulatory bodies. Once the new technology has been approved by the Medical Management Quality Committee, the Sanford Health Plan Board of Directors will be presented with the proposal for inclusion into the benefit package.
8. **EXCLUSIONS:** Certain services or medical supplies are not covered. You should refer to your Policy for a detailed explanation of all exclusions.
9. **CONTINUATION:** You may convert to individual coverage or continue coverage under certain circumstances. These continuation and conversion rights are explained fully in your Policy.
10. **CANCELLATION:** Your coverage may be canceled by you or the Plan under certain conditions. Your Policy describes all reasons for cancellation of coverage.
11. **NEWBORN COVERAGE:** A newborn infant is covered from birth. The Plan will not automatically know of the infant's birth or that you would like coverage under your plan. You should notify the Plan of the infant's birth and that you would like coverage. If your contract requires a service charge for each dependent, the Plan is entitled to all service charges due from the time of the infant's birth until the time you notify the Plan of the birth. The Plan may withhold payment of any health benefits for the newborn infant until any service charges you owe are paid. See your Policy for information on children placed for adoption.
12. **PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT:** Enrolling in the Plan does not guarantee that any particular prescription drug will be available or covered nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the contract year. Sanford Health Plan covers prescribed drugs and medications according to our Formulary. Additional drugs may be added or removed from the formulary throughout the year. Sanford Health Plan will notify you of any formulary changes. For a copy of the Plan formulary, you can contact our Member Services Department at (605) 328-6800 or toll free at 1-800-752-5863 or you can view the formulary online at www.sanfordhealthplan.com.
13. **MEDICAL NECESSITY:** Means health care services that are appropriate, in terms of 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 practice parameters as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and
 - B. help restore or maintain the member's 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; and
 - E. not be considered experimental or investigative.
14. **PRACTITIONER:** A professional who provides health care services. Practitioners are usually required to be licensed as required by law.
15. **PROVIDER:** An institution or organization that provides services for Plan Member's. Examples of Providers include hospitals and home health agencies.

CONSUMER INFORMATION FOR COMPREHENSIVE SUPPLEMENTAL (OUT OF NETWORK) BENEFITS

1. **COVERED SERVICES:** The comprehensive Out of Network benefit of the Plan covers similar services as the comprehensive health maintenance services, but at a different level of coverage. Copayments, deductibles,

and maximum lifetime benefit restrictions may apply. Your Policy describes the procedures for receiving coverage through the comprehensive Out of Network benefit.

2. **PROVIDERS:** To receive services through the comprehensive Out of Network benefit, you may go to providers of covered services who are not on the provider list supplied by the Plan and for whom you did not get a referral.
3. **REFERRALS:** A referral from the Plan for services covered by the comprehensive Out of Network benefit is not required to receive coverage. However, if a referral is requested from the Plan you may be eligible for the same services, from the same provider at a lower cost to you (or at the In Network level), as a benefit under your comprehensive health maintenance services. See your Policy for specific referral details.
4. **PRIOR AUTHORIZATION:** You are not required to get prior authorization from the Plan before using Out of Network benefits. However, there may be a reduction in the level of benefits available to you if you do not get prior authorization. See your comprehensive Out of Network benefit agreement in your Policy for specific information about prior authorization.
5. **EXCLUSIONS:** Coverage of Out of Network benefits is limited to those services specified in your Policy which lists related services that are excluded from coverage and clarifies any limitations imposed on coverage of the services.
6. **CONTINUATION:** Your comprehensive health maintenance services contract provides for continuation and conversion rights under certain circumstances. If you continue your coverage as an individual under your group contract, the comprehensive Out of Network benefits will also continue. If you convert to an individual plan, Out of Network benefits may not be available. Your continuation and conversion rights are explained fully in your Policy.
7. **DISCONTINUATION:** Your comprehensive Out of Network benefits is an addition to your comprehensive health maintenance coverage. Changes in your contract may result in the discontinuation of one or more of your Out of Network benefits. Please read all amendments to your Policy carefully.

MEMBER SERVICES DEPARTMENT

The Plan believes that good service depends on good communication with members. We encourage you to contact the Plan's Member Services Department at (605) 328-6800 or 1-800-752-5863 for assistance when you need it. A Member Services Representative will be happy to assist you with questions regarding your benefits coverage. The Plan's office hours are from 8:00 a.m. to 5:00 p.m. Central Time, Monday through Friday.

SPECIAL COMMUNICATION SERVICES

A. Interpreter Services

The Member Services and Utilization Departments have access to interpreter services in order to coordinate services by phone. A member who speaks a foreign language may request a Plan representative contact the Language Line Service at 1-800-874-9426, Lutheran Social Services at 1-866-242-2447 or A-2-Z at 1-800-757-3775 in the language of their choice. Once an interpreter is contacted, a three-way conversation will take place between the member, Plan representative and the interpreter.

B. Services for Hearing Impaired

Hearing impaired members wishing to speak to Member Services may contact:

- Communication Services for the Deaf at (605) 362-3507 and ask for the head scheduler to arrange for an interpreter;
- Community Resources for the Deaf at (605) 367-5759; or
- For hearing impaired Members in surrounding states, A Relay System is available by calling 1-800-877-1113.

C. Services for Visually Impaired

The Plan will make available upon request large print Handbooks for visually impaired members. Please contact our Member Services Department if you are in need of a large print copy or cassette/CD of the Handbook or other member materials.

YOUR IDENTIFICATION CARD

When to use your ID Card

You and each of your family members enrolled with the Plan will receive an individual Sanford Health Plan Identification (ID) Card. You are responsible for carrying this card with you at all times and presenting your ID card, along with any other insurance, every time you receive medical services from a provider or pharmacy. Familiarize yourself with your card to make sure the information is correct.

Your identification card contains member specific information on the front of the card. The reverse side of the card provides directions for emergency, urgent care or out-of-area services as well as important telephone numbers if you have questions or need assistance regarding the plan, its providers, or covered benefits.

Anytime your basic enrollment information changes, you should report it to your employer. Your employer will then provide you with the correct forms to complete. Examples of basic information which should be reported to your employer are:

- A name change;
- A change in marital status; or
- Addition or deletion of a family member or dependent.

What to do if you haven't received your ID card, but need healthcare services:

If you haven't received your ID card and need to see a doctor, please do the following:

1. Verify the physician or facility are participating providers with Sanford Health Plan by either calling Member Services or checking your Provider Directory online at www.Sanfordhealthplan.com.
2. Inform the clinic/facility at check-in that you are currently enrolling with the Plan and provide them with your Social Security Number.
3. Call the clinic/facility as soon as you receive your ID card to verify all necessary information to ensure proper claims submission and payment.

If you haven't received your ID card but you need to have a prescription filled, please do the following:

1. You will be required to pay the pharmacy in full for the prescription if your Plan application has not been processed.
2. Your pharmacy may be able to re-process your claim if you provide your ID card to the pharmacy within *ten (10)* days from the date that the prescription was filled. This will allow for automatic reimbursement. If this is not possible, you will need to submit a claim form and itemized prescription drug receipt to the Plan for reimbursement. Claim forms are available in your employer Human Resource/Benefits office.

Always remember, the identification card is to be used only by the person listed on the card. It may not be used by anyone else. Use of your card by another person is fraud and will be grounds for termination from the Plan. Should you need to replace a lost card, please call the Member Services Department at (605) 328-6800 or 1-800-752-5863 and we will send you a new one.

YOUR BENEFITS

As a Plan Member, your benefits package is one of the most comprehensive available today. Basic primary care and preventative benefits are available through your primary care physician or other Participating Providers. Please see your [Summary of Plan Benefits](#) and your [Policy](#) for a description of covered services, as well as those which are excluded and/or limited.

A. 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 if you applied, the first day of a waiting period. The *one (1) year* period shall be reduced by the aggregate number of days that you were 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). 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 you do 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.

Exclusions and Limitations to Coverage

The following is a list of some of the services and supplies that are excluded from coverage. When you enroll, your [Policy](#) you receive will provide a complete, detailed list of exclusions. You may contact Sanford Health Plan for a [Policy](#) for specific information about excluded services and supplies.

B. 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. The Member will not be responsible for services performed by a participating provider that are beyond the scope of practice authorized by law for the type of Practitioner performing them under the state law.
3. Health Care Services performed by any Provider who is a Member of the enrollee'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 enrollee 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 enrollee must go to a Participating Provider in order to receive coverage (at the in network level).
4. Health certifications and services when required by third parties, including for the purpose of insurance, licensure and employment and when such services are not preventative care or otherwise medically necessary:
 - 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).
5. Health Care Services received for any disease or injury suffered as a result of or while in military service, provided that such services are available under another program of coverage.
6. Health Care Services ordered by a court or as a condition of parole or probation received from an Out of Network provider, except as described in this Policy.
7. Experimental and Investigational Services.
8. Complications from a non-covered procedure or service.
9. Charges for telephone calls to or from a physician, hospital, or other medical provider.
10. Health Care Services that the Plan determines are not medically necessary.
11. Services not performed in the most cost-efficient setting appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate.
12. Services, including transfers and admissions to *hospitals*, performed only for the convenience of the *member*, the *member's* family or the *member's physician* or other *provider*.
13. Services for, or related to, rehabilitation services, such as physical, occupational, and speech therapy, or such services provided in the *members'* home for convenience, that are not expected to make measurable or sustainable improvement within a reasonable period of time. Services that are primarily *educational* and provided for the purpose of correcting speech impediments (stuttering or lisps), or assisting the initial development of verbal facility or clarity; voice training and voice therapy.
14. Cochlear implants.
15. Professional sign language and foreign language interpreter services in a *physician's* office.
16. Nutritional and electrolyte substances and infant formulas, except to treat PKU or otherwise required to sustain life.
17. Nutritional counseling, except when provided during a *confinement* or for the diagnosis and treatment of a medical condition affected by diet. Policy guidelines apply.
18. Services for, or related to, Methadone or Cyclazocine.
19. Charges for duplicating and obtaining medical records from *non-participating providers* unless requested by *the Plan*.
20. Services primarily *educational* in nature; vocational and job rehabilitation; recreational therapy.
21. Mental or substance-related disorder services, including marital or family counseling, bereavement, pastoral, or custodial care counseling or other similar counseling or training services, treatment of mental health disorders or substance-related disorders that *the Plan* determines cannot be improved with treatment, except as stated in this *Policy*. However, this exclusion does not apply to outpatient family therapy that is recommended by a *provider* treating a minor *dependent* child.
22. Services for, or related to, mental retardation or mental disorders that, according to generally accepted professional standards, is not amenable to favorable modification, except for initial evaluation, diagnosis or crisis intervention.
23. Services to hold or confine a *member* under chemical influence when no *medically necessary* services are required, regardless of where the services are received (e.g. detoxification centers).
24. Any durable medical equipment or supplies not on *the Plan's* eligible list, as determined by *the Plan*. Except as specifically noted in this *Policy*, *the Plan* does not cover the following equipment and supplies:
 - Orthopedic shoes; orthotics and appliances;

- Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage;
 - Revision of durable medical equipment and prosthetics, except when made necessary by normal wear or use;
 - Replacement or repair of items, if the items are damaged or destroyed by the *member's* misuse, abuse or carelessness, lost, or stolen;
 - Duplicate or similar items;
 - Service call charges, labor charges, charges for repair estimates;
 - Items that are primarily *educational* in nature or for vocation, comfort, convenience or recreation;
 - Household equipment that primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, allergenic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools;
 - Household fixtures: fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas;
 - Home Modifications: modifications to the structure of the home including, but not limited to, its wiring, plumbing or charges for installation of equipment;
 - Vehicle/car or van modifications: modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier;
 - Other equipment and supplies that *the Plan* determines are not eligible for coverage.
 - Over the Counter equipment, supplies and appliances.
25. Charges for sales tax, mailing, interest and delivery.
 26. Financial or legal counseling services.
 27. Routine foot care including cutting, removal, or treatment of corns, calluses, or nails, except for *members* who have diabetes or peripheral vascular disease.
 28. Genetic testing, excluding testing for reproductive planning and testing that will direct patient care or treatment of a medical condition. Policy guidelines apply.
 29. Charges for services determined to be duplicate services by *the Plan* medical director or designee.
 30. Services payable by Medicare.
 31. Charges that exceeds the *usual and customary amount* for Non-Participating Providers.
 32. Telephone or electronic mail consultations.
 33. Any service not specifically described as covered services in the *Policy*.
 34. Organ Transplant:
 - a. expenses related to transplants of animal organs.
 - b. artificial organs.
 - 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. Services, chemotherapy, radiation therapy (or any therapy that damages the bone marrow), supplies, drugs and aftercare for or related to artificial or nonhuman organ implants.
 - e. Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by *the Plan's* medical director or its designee.
 - f. Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan contracted, Center of Excellence.
 - g. Costs related to locating and/or screening organ donors.
 35. Cosmetic Surgery including skin tag removal and other supplies and services used to repair or reshape a body structure primarily for the improvement of a covered person's appearance or psychological well-being or self-esteem. Excluding conditions that are not the result of disease, trauma, congenital, or developmental abnormalities, which are meant to improve appearances, including but not limited to breast augmentation, rhinoplasty, liposuction, scar revisions, and cosmetic dental services.
 36. Hypnotism, Hypnotherapy, Hypnotic Anesthesia, and Sleep Therapy (except for central or obstructive apnea when approved by the Plan).
 37. Accupressure, Aquatic Therapy, Biofeedback, Massage Therapy, Fluidotherapy, Naturopathy, Homeopathy, Holistic Medicine or Therapeutic Touch.
 38. Diagnosis and Treatment of Weak, Strained, or Flat Feet, unless determined by the Plan to be Medically Necessary.
 39. Correction of Refractive Errors of the Eye, Purchase, Examination, or Fitting of Eyeglasses or Contact Lenses, except as specifically covered elsewhere.
 40. Radial Keratotomy, Myopic Keratomileusis, and any Surgery Involving Corneal Tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error.
 41. Sexual Re-assignment, including, but not limited to, surgery unless deemed medically necessary.

42. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics.
43. Non-Emergency Ambulance Services and/or Travel, unless approved and arranged by the Plan.
44. Costs Associated with Private Rooms, above the semi-private room rate of the institution, except as specifically covered elsewhere.
45. Private Duty Nursing, except as specifically covered elsewhere.
46. Confinement in a Nursing Home, for custodial, convalescent, intermediate level, or domiciliary care, residential care, rest cures or care, or services to assist in activities of daily living.
47. Medical nutrition therapy for diabetic care does NOT include food items or nonprescription drugs.
48. Hot and cold packs provided by a physician, chiropractors, or other licensed providers.
49. Sterilization of Dependent Children.
50. 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;
 - vii. Supplies related to artificial means of conception;
 - b. reversals of prior sterilization procedures; and
 - c. expenses related to surrogate parenting.
51. Abortion Services.
52. Wigs, Scalp Hair Protheses or Hair Transplants, except as specifically covered elsewhere.
53. Dental Services, not specifically listed as a Covered Service, including dental x-rays, shortening of the mandible or maxillae for cosmetic purposes.
54. Services and Supplies Related to Ridge Augmentation, Implantology, and Preventive Vestivuloplasty.
55. 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.

D. Drug Exclusions

Please review the following information concerning the drug exclusion and quantity limit listings. Additional drugs may be added throughout the year to any listing. Sanford Health Plan will notify you of any changes. If you have any questions or concerns contact our Utilization Department at 800-805-7938.

Excluded Drugs and Supplies

The following are specifically **EXCLUDED** from coverage under the plan unless mandated by State regulation:

1. Drugs not listed in the Sanford Health Plan Formulary or without certification or a formulary exception from the plan.
2. Medications, equipment or supplies available over-the-counter (OTC) (except for insulin, insulin syringes or tobacco cessation products as covered elsewhere in this certificate) that by federal or state law do not require a prescription order; any medication that is equivalent to an OTC medication; drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless Provider certifies off-label use with a letter of medical necessity).
3. *Prescription drugs* for smoking cessation in excess of a 6-month supply per *calendar year*.
4. Weight loss drugs except when *medically necessary* to treat morbid obesity.
5. Replacement of a *prescription drug* due to loss, damage, or theft.
6. Outpatient Drugs Dispensed in a Provider's Office or non-retail pharmacy location.
7. Orthomolecular Therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multi-vitamins with iron and/or fluoride, and food supplements and baby formula.
8. Whole Blood and Blood Components Not Classified as Drugs, in the *United States Pharmacopoeia*.
9. Experimental or Investigational Drugs or Drug Usage that does not meet the criteria set forth in the definitions section of this certificate.
10. B-12 Injections, except for pernicious anemia.
11. Drug Efficacy Study Implementation ("DESI") drugs.
12. Drugs that may be received without charge under a federal, state, or local program.
13. Drugs for cosmetic purposes, including baldness.
14. Refills of any prescription older than one year.
15. Compound medications with no legend medications.

16. Acne Medication for Members over ages thirty-five (35).

KNOW YOUR SERVICES AND USE THEM APPROPRIATELY

This Member Handbook is merely a summary of the Plan's benefit offerings. Some benefits may be subject to certain limitations, exclusions, copayments, coinsurances, and deductibles as provided by your benefit plan. Every member receives a Policy as well as a Summary of Plan Benefits. The Policy, along with any Attachments and appropriate supplemental riders, describes the health care services provided to you by the Plan. The Summary of Plan Benefits further outlines the specific restrictions, copayments, coinsurances, and deductibles as provided by your benefit plan.

Please refer to these materials for information regarding your benefit coverage. If you have any questions about your benefits, please call the Plan's Member Services Department at (605) 328-6800 or 1-800-752-5863.

EMERGENCY SITUATIONS

A. In-Area Emergency Services

If an Emergency Condition arises while you are in our Service Area, 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 precertification 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.

B. Out-of-Area Emergency Services

If an *emergency* condition arises when traveling outside of the Plan's service area, you should go to the nearest emergency room to receive care or call 911. You or a designated relative or friend must notify the Plan and your primary care physician, if you have selected one, as soon as reasonably possible, and no later than *forty-eight (48)* hours after becoming physically or mentally able to give notice. In-Network coverage will be provided for emergency conditions outside of the service area unless you traveled outside the service area for the purpose of receiving such treatment.

LEVELS OF COVERAGE

There are two levels of coverage that are available, In-Network coverage and Out-of-Network coverage which are both described below. As indicated in your 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.

A. In-Network Coverage

In-Network coverage means covered services that are either received:

- a) from a Participating Provider;
- b) in an emergency medical condition or urgent care situation;
- c) when you do 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, Mental Health/Substance Abuse and Hospital Providers is within *thirty (30)* miles of a Member's city of residence and for other Providers it is within *sixty (60)* miles of a Member's city of residence.

The following Health Care Services may be accessed through network or non-network providers and are covered at the in-network coverage level:

- i. the voluntary planning of the conception and bearing of children;

- ii. the diagnosis of infertility;
- iii. the testing and treatment of a sexually transmitted disease; and the testing for AIDS or other HIV-related conditions.

B. Out-of-Network Coverage

(NOTE: This Section does not apply to Members enrolled in certain Plans with no out-of-network coverage).

Out-of-Network coverage means covered services that do not fit the definition of In-Network coverage as set forth above. Specifically, Out-of-Network coverage means covered services that you receive:

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

Members who live outside of the Plan's service area must use the Plan's contracted network of participating providers as indicated on the Welcome Letter enclosed with your Identification Card. Members who live outside the service area will receive Identification Cards that display your network logo along with instructions on how to access this network. If you choose to go to a Non-Participating provider when access is available, claims will be paid at the Out-of-Network benefit level.

C. Member Cost Sharing

As indicated in your Summary of Plan Benefits, copayments and deductibles apply. Copayments and deductibles for Out-of-Network coverage are higher than the copayments and deductibles for In-Network coverage. The amount charged as copayment is based on the allowed amount a provider charges for that category of services. The Plan has developed flat fee copayments for certain categories of similar service as described in the Summary of Plan Benefits (i.e. medical office visits, specialty care, preventive health services, emergency services, mental health/chemical dependency service, and chiropractic services.) Coinsurance means the percentage of charges to be paid by a Member for covered services at the time such services are rendered. Coinsurance is calculated on the discounted provider charge. You may be required to pay either a copay or coinsurance at the time services are rendered, but you will not be required to pay both.

WELLNESS PRINCIPLES

It is better for both you and the Plan if you are seen in your primary care physician's office when you are healthy so that he or she can work with you to keep you healthy instead of trying to treat you when you are already ill. That is why we encourage you to select a primary care physician to coordinate your care and to offer you such services as yearly physical exams, maternity care, annual gynecological exams, and immunizations. The Plan has a commitment not only to treating you when you are ill, but also to helping you stay well. We will provide directly to you, as well as make available to you in your Practitioner and/or Provider's office, educational and wellness materials to teach you how to stay fit and live a healthy life: physically and mentally.

A. Preventive Health Guidelines

Health promotion and disease prevention is our best opportunity to reduce the ever-increasing portion of resources spent to treat illnesses and impairments that could have been prevented. As a health plan we would not be doing our jobs if we did not educate our members on how to cut health care costs, prevent premature onset of disease and disability, and help all people achieve healthier, more productive lives.

Age specific preventive health guidelines describe the prevention or early detection interventions and recommended frequency and conditions under which the interventions are required. Age specific is defined as prenatal and perinatal, infants up to *twelve (12)* months, children and adolescents *one (1) – seventeen (17)* years, adults *eighteen (18) – sixty-four (64)* years, and the elderly *sixty-five (65)* years and older. Documentation supports the scientific basis on which the guidelines were adopted.

Members of the Plan are encouraged to utilize preventive health services and to receive health education by reading newsletters and attending publicized preventive health services educational classes. The Plan also has immunization schedules available for parents that contain the recommended immunizations from birth through age *sixteen (16)*. The immunization guidelines are adopted annually from the Advisory Committee on Immunization Practices, the American Academy of Pediatrics, the American Academy of Family Physicians and the Centers for Disease Control and Prevention. If you would like a copy of the Plan's Preventive Health Guidelines or an immunization schedule, please contact our Member Services Department at (605) 328-6800 or 1-800-752-5863 or refer to our website at www.sanfordhealthplan.com.

FINDING PARTICIPATING PRACTITIONER AND/OR PROVIDERS

Sanford Health Plan participating providers can be found on our website at www.sanfordhealthplan.com or call Member Services at (605) 328-6800 or toll free at 1-800-752-5863 if you do not have access to our website.

If you do not have access to a Sanford participating provider, please call Member Services to locate a participating provider outside of the Sanford Health Plan service area. If you choose to go to a non-participating provider when access is available, your claims may be denied or paid at a reduced level.

YOUR PRIMARY CARE PHYSICIAN

A Primary Care Physician (PCP) is one who practices any of the following specialties: Internal Medicine, Family Medicine (General Practice), Pediatrics or Obstetrics and Gynecology. The PCP's responsibilities for Plan Members include: evaluating the member's needs, recommending and arranging the services required by the member, and facilitating communication and information exchange among the different Practitioner and/or Providers treating the member. Members have the right to select a PCP of their choice. If a member is dissatisfied for any reason with the PCP initially chosen, he or she has the right to choose another available PCP. Even though you may choose to see any Participating Provider at any time, we encourage members to use their PCP whenever possible because we believe that having a health care Practitioner and/or Provider who knows you well is the best way to keep you healthy.

In order to make it convenient for you and your family to receive health care services through the Plan, each enrolled member of your family may select his or her own PCP from our directory of Participating Providers. For instance, you may select a PCP whom you have been seeing for some time, but would prefer to have your children see a PCP who is closer to your home. The Plan's Member Services Department is available to assist you in selecting a Practitioner and/or Provider by providing information on the location of the providers' offices and their specialties.

Your PCP can assist you in the management of all your health care needs and you should contact him or her whenever you require care. Your PCP can coordinate with the Plan's Medical Director for any questions regarding specialty care or services you may need. (See *Specialty and Behavioral Health Services* below).

Be sure to call your PCP's office in advance to schedule an appointment for care. **When you arrive at the office, always show your Identification Card.**

A. After Hours Care

Your primary care physician has agreed to be available to you personally or through another Practitioner and/or Provider, *twenty-four (24) hours a day, seven (7) days a week* for emergency and urgent care. Be sure to call during normal office hours for routine situations and only call after hours in URGENT or EMERGENCY situations. Leave a message with the answering service and, in accordance with Plan standards, your primary care/physician's office will return your call within *thirty (30) minutes* or as soon as possible thereafter. For more information please see the section on *Emergency Situations*.

B. Transition of Care from a Non-Participating Provider to a Participating Provider

If you are currently receiving treatment from a physician of facility that is not part of the Sanford Health Plan network, you must complete a "Transition of Care" form and submit it to the Plan. *Transition of Care* forms are available in your employer's Human Resource/Benefits office. You will be notified by the Utilization Department regarding the approval or denial of your request.

C. Specialty & Behavioral Health Services

The Plan works with a large network of Participating Providers from nearly every medical specialty to give you direct access to the health care services you need. A Participating Provider will refer you to the proper participating specialist or behavioral health specialist or you may choose to see a participating specialist or behavioral health specialist, on your own at any time for services you require (please see your Provider Directory at www.sanfordhealthplan.com for a list of In-Network Providers). If you are having difficulty obtaining an appointment with a mental health Practitioner and/or Provider, you may contact the Behavioral Health Triage by calling (605) 328-4777 or toll free at 1-888-996-4673. However, we encourage you and your family members to maintain an ongoing relationship with a Primary Care Physician (PCP). A PCP is a valuable link to achieving and maintaining good health. If you are referred to an Out-of-Network Provider, prior authorization is required from the Plan. If prior

authorization is approved, Out-of-Network Providers will be paid at the In-Network benefit level. Please see *the Prior Authorization* section in this Handbook and the *Levels of Coverage* Section in this Handbook or your Policy.

D. Mayo Clinic, Rochester, Rochester Methodist & St. Mary's

You must have certification from Sanford Health Plan to make an appointment and receive services from the Mayo Clinic, Rochester, or St. Mary's. Please contact our Utilization Department at (605) 328-6807 or toll free at 1-805-7938 for certification should your physician refer you to the Mayo Clinic for services.

E. Foreign Language Providers

If you would like a listing of Practitioner and/or Providers who speak languages other than English, please contact our Provider & Payor Relations Department toll free at 1-877-305-5463. A listing will be sent directly to your home upon your request.

F. Physician Qualifications

If you have any questions or would like additional information about your Physician's qualifications, please call (605) 328-6877 or toll free at 1-877-305-5463.

UTILIZATION DEPARTMENT FUNCTIONS

The Utilization Department performs three primary functions: Utilization Review, Case Management, and Discharge Planning. The Utilization Department is available to practitioners and Members to discuss utilization review issues between the hours of 8:00am to 5:00pm CST, Monday through Friday (excluding holidays). The Utilization Department's toll free number is 1-800-805-7938. After hours callers may leave a message on the confidential voicemail of the department and a Utilization Management Representative will return their call the following business day.

A. Case Management

Case Management is a holistic system of care that integrates, coordinates, and advocates for individuals, families, and groups requiring extensive services. It is a coordinated set of activities conducted for individual member management of serious, complicated, protracted or other health conditions. The ultimate goal is to achieve planned care outcomes by brokering services across the health care continuum.

B. Discharge Planning

The Utilization Management Coordinator begins assessing discharge planning needs at the beginning of any hospital admission. The reviewer assists in the identification of members with post hospital care needs for which social service and hospital discharge planning services would be appropriate. The Utilization Management Coordinator can, with the advice and counsel of the attending physician, work actively with social service and hospital discharge planning to assist in coordinating inter-hospital transfer, transfers to nursing homes, home health care, transportation, and any durable medical equipment needed.

C. Utilization Review

The Utilization Department evaluates the necessity, appropriateness, and efficacy of the use of health care services, procedures and facilities for the purpose of determining the medical necessity of the service or admission. This process is called "Utilization Review." There are three types of utilization reviews:

1. Prior Authorization;
2. Concurrent Review; and
3. Retrospective Review.

Each case is subject to specific decision and notification time standards, per State law and National Committee for Quality Assurance (NCQA) standards. All utilization management adverse determinations will be made by Sanford Health Plan's Medical Director or a Provider of similar or same specialty.

Prior Authorization of Services (Pre-service)

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.

Prior authorization (preservice review) is not required for emergency conditions. However, we must be notified as soon as reasonably possible and no later than *forty-eight (48)* hours after you are physically or mentally able to do so. Additionally, because of the inability to predict admission, obstetrical admissions shall be certified authorized

when the pregnancy is confirmed. The exception is that of an elective C-section, which must be prior authorized as an elective admission.

Our Utilization Department is available between the hours of 8:00a.m. and 5:00p.m. Central Time, Monday through Friday, by calling our toll-free number 1-800-805-7938 or (605) 328-6807. After hours you may leave a message on the confidential voice mail of the Utilization Department and someone will return your call. **You are ultimately responsible for obtaining prior authorization from the Utilization 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. (NOTE: For Employer Groups who purchase Plans with no out-of-network coverage, benefits are not payable when you fail to obtain certification).

The Utilization Department will review member profile information against standard criteria. Determinations and notifications of decisions to the member and Practitioner and/or Provider are made by the Utilization Department within the timeframes required by state law and NCQA standards. Urgent care request determinations are made as soon as possible but no later than the timeframe required by state law and NCQA standards. Certain circumstances may allow for an extension, for example, due to lack of necessary information to make the determination. Please refer to your Policy for Sanford Health Plan's procedure for timely handling of Prospective review requests and for details on extensions for special circumstances.

a. Services that Require Prior Authorization Include:

- Inpatient hospital admissions including admissions for medical, surgical, neonatal intensive care nursery, mental health and chemical dependency services;
- Partial Hospital Program (PHP)/Day Treatment for mental health and chemical dependency services;
- Selected Outpatient Surgeries;
- Home Health, Hospice and Home IV therapy services;
- Durable Medical Equipment (rental or purchase over \$200);
- Acupuncture when requesting more than twelve (12) sessions/visits.
- One water rehabilitative therapy;
- Skilled nursing and sub-acute care;
- Organ transplants;
- PET Scans; 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.

b. Prescription Drugs that Require Prior Authorization

To be covered by the Sanford Health Plan, certain medications require prior authorization or a letter of medical necessity for a formulary exception. This can be in the form of written or verbal authorization. To request verbal authorization, you or your Practitioner and/or Provider must contact the Utilization Department at 800-805-7938 between 8 a.m.-5 p.m. Monday through Friday. Please refer to your Policy for a Complete list of Prescription Drugs that Require Prior Authorization.

Fax a letter of Medical Necessity to Health Services at (605) 328-6812.

Urgent/Emergency Medical and Behavioral Health Care and Pharmaceutical Requests (Urgent Pre-service)

"Emergency" or **"Emergency Condition"** means a medical or behavioral condition that manifests itself by symptoms of sufficient severity, including, but not limited to, severe pain, that a prudent layperson, possessing an average knowledge of medicine and health, could reasonably expect the absence of immediate medical attention to result in (a) placing the health of the person afflicted with such condition in serious jeopardy or, in the case of a behavioral condition, placing the health of such person or others in serious jeopardy, (b) serious impairment to such person's bodily functions, (c) serious impairment of any bodily organ or part of such person, or (d) serious disfigurement of such person.

An **"Urgent Care Situation"** is a situation with a degree of illness or injury which is less severe than an Emergency Condition, but requires prompt medical attention within *twenty-four (24) hours*.

An “**Urgent Care Request**” means a request for a health care service or course of treatment with respect to which the time periods for making a non-urgent care request determination:

- (1) Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function based on prudent layperson’s judgement; or
- (2) In the opinion of a Physician with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

In determining whether a request is “urgent,” the Plan shall apply the judgment of a Prudent Layperson as defined in Section 8. A Physician, with knowledge of the Member’s medical condition, who determines a request to be “urgent” within the meaning of subdivisions (1) and (2) in this paragraph shall be treated as an Urgent Care Request.

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, your or your practitioner must notify the Plan of your expected due date when the pregnancy is confirmed. You must also notify the Plan of the date of scheduled C-sections when it is confirmed.

Concurrent Medical and Behavioral Health Care Reviews

Concurrent review” is utilization review conducted during a patient’s hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting. It 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. Additional stay days must meet the continued stay review criteria and, if acute level of care criteria is not met, a decision to authorize further treatment must be made at that time.

The Utilization Department will review member profile information against standard criteria. Determinations and notifications of decisions to the member and Practitioner and/or Provider are made by the Utilization Department within the timeframes required by State law and NCQA standards. *Urgent care request* determinations are made as soon as possible but no later than the timeframe required by state law and NCQA standards. Please refer to your Policy for Sanford Health Plan’s procedure for timely handling of Prospective (pre-service review) requests.

Retrospective Medical and Behavioral Health Care Reviews (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. For retrospective review *decisions*, Sanford Health Plan will give written notification of the decision to the Member, practitioner and those Practitioner and/or Providers involved in the provision of the service within *thirty (30) calendar days* of the request.

FORMULARY

The Plan’s Formulary is a list of medications that are often the most effective for the treatment and diagnosis of disease and maintenance of health according to the clinical judgment of the physicians, pharmacists and other health care professionals who helped us develop the Formulary. Not all drugs are covered, please refer to the “Drug Exclusion List” below or contact our Member Services Department at (605) 328- 6800 or toll free at 1-800-752-5863 for a copy of the Plan’s Formulary.

Following the Plan Formulary will save you money and help control the costs of health care. When you, your Practitioner and/or Provider prescribes a drug for you, you can ask that he or she refer to the Plan Formulary for prescription options. All Participating Providers have received a copy of the Plan Formulary on your behalf.

Exception to formulary. The health plan will use a Practitioner and/or Providers of the same or similar specialty to consider exception requests and promptly grant an exception to the drug formulary, including exceptions for anti-psychotic and other mental health drugs, for a Member when the health care Practitioner and/or Provider prescribing the drug indicates to the health plan company that:

- (1) the formulary drug causes an adverse reaction in the patient;
- (2) the formulary drug is contraindicated for the patient; or
- (3) the health care Practitioner and/or Provider demonstrates to the health plan that the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

The Plan has options of Open, Closed, 2-Tier, and 3-Tier formulary systems for your employer's choice to best meet the needs of the company. Please refer to your Summary of Plan Benefits for the Formulary Benefit purchased by your employer.

An **Open Formulary** is a list of medications that are recommended by Express Scripts Inc., on behalf of the Plan. This list is used only to encourage Practitioner and/or Providers to prescribe appropriate medications. All drugs are covered as defined by the benefit package.

A **Closed Formulary** is a list of certain medications that are covered and others that are not covered by the Plan. If a prescription is written for a medication that is not on the formulary list, the member is responsible in full for the cost of the medication. If a member or their Practitioner and/or Provider feels that a certain drug is medically necessary for their condition an appeals process is available. Refer to the *"Exception to the Formulary"* Process in this handbook and your Policy.

A **2-Tier and 3-Tier Formulary** uses a copayment structure that reduces your out-of-pocket costs when using generic drugs and formulary brand name drugs. It does not provide for preferred medication as a way to control costs. When a prescription is filled, your copayment will be at one of these tiers:

2-Tier Formulary:

- Tier 1: Generic Drugs (lowest copay)
- Tier 2: All covered Brand Name Drugs (higher copay)

3-Tier Formulary:

- Tier 1: Generic Drugs (lowest copay)
- Tier 2: Formulary Brand Name Drugs (higher copay)
- Tier 3: Non-Formulary Brand Name Drugs (highest copay)

A **brand name drug** is a drug manufactured and marketed under a trademark or name by a specific drug manufacturer. A **generic drug** is a medication chemically equivalent to a brand-name drug whose patent has expired.

To be covered by the Plan, drugs must be:

1. Prescribed or approved by a physician;
2. Listed in the Plan Formulary, unless prior authorization or a formulary exception is given by the Plan;
3. Provided by a Participating Pharmacy and obtained through use of your ID card, except in the event of a medical emergency. If the prescription is obtained at a Non-Participating Pharmacy you are responsible for the prescription drug cost in full. If you fail to utilize your prescription drug card, except in an emergency, you are responsible for manually filing a paper claim with the Plan and must accept a reduced level of reimbursement. Reimbursement will be at the rate that would have been paid by the Health Plan had you used your ID card.
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

Please refer to the following documents for specific information on the following topics:

1. Summary of Plan Benefits – describes the payments for which you are responsible when purchasing prescription drugs and supplies.
2. Policy – describes how and where to obtain your prescription drugs and supplies, dispensing limitations, and excluded drugs and supplies.
3. Sanford Health Plan of Minnesota Formulary – describes specific information on drug exclusions, prior authorization drugs, quantity level limits on drugs and the Plan's Injectable drug program.

If you feel that the Plan should consider coverage of a medication based on medical necessity for medications **not** on the Formulary, please follow the *"Exception to the Formulary"* process found in this handbook and your Policy.

For online access to the Plan's Formulary, Pharmacy Network, drug information and education, and your prescription history go to www.sanfordhealthplan.com and select Member Pharmacy Information-.

QUALITY IMPROVEMENT PROGRAM

The Plan and its Participating Providers acknowledge their responsibility to provide high quality care in a cost-effective manner through an ongoing monitoring, evaluation and improvement process. The organized method for

monitoring, evaluating, and improving the quality, safety and appropriateness of health care services, including behavioral health care, to members through related activities and studies is known as the Quality Improvement (QI) program. QI also addresses the quality of non-clinical aspects of service, including availability, accessibility, continuity and coordination of care, case management, discharge planning, prior authorizations, provider reimbursements, and complaints and appeals.

A. Quality Committees in the Plan

The Board of Directors maintains the ultimate authority over the Plan's Quality Improvement Program. In order to implement the Plan's Quality Improvement Program, the Board has delegated its responsibility for monitoring the organization's Quality Improvement Process to the Medical Director, through a formal Board resolution. The Medical Director, along with the help of the Quality Improvement Committees, ensures that the Board meets its responsibility to monitor, evaluate and revise the clinical and service quality issues and care delivery system. The Health Plan Quality Improvement Committee is made up of Plan directors and staff and is charged with supporting the Plan's Board of Directors and Medical Director in meeting quality assurance goals on issues of service. The Medical Management Quality Committee consists of physician members appointed at staggered terms. This Committee is charged with supporting the Plan's Board of Directors and Medical Director in meeting quality assurance goals on issues of care. They also have the responsibility of developing and continually evaluating the review criteria used in the evaluation of appropriate utilization.

B. Quality Improvement Activities

The Plan conducts, at a minimum, three quality improvement activities a year. Topics for activities are directed at problems, potential problems, or areas with potential improvements in care and service based on demographic characteristics, including age and sex of the member. Topics will also be based on areas of high volume, areas of high risk, areas that can be corrected or where prevention may have an impact, and areas where complaints have occurred. An Annual Work Plan describes the topics to be studied, the rationale for choosing the topic, the expected benefits to be gained from the study, as well as the study methodology, sample size, and criteria to be used for evaluation.

C. Disease Management Programs

Sanford Health Plan of Minnesota has developed a prospective disease-specific approach to the management of our Members' chronic medical conditions. The emphasis of these programs is disease prevention and wellness education for targeted members and physicians to improve the overall health, wellness and quality of the Member's life.

Currently, Sanford Health Plan of Minnesota has Disease Management Programs for diabetes, asthma, healthy pregnancy, and congestive heart failure. All of these Disease Management Programs involve identifying eligible Members for participation in the program through the Plan's administrative data like claims data. These eligible Members receive an initial program packet which contains an outline of how to use the program's services, the types of interventions that are involved and how to contact the Plan regarding any questions related to the program or its services (see below for details). To opt out of the program, you need only to complete the Non-Participant form that accompanies the initial program packet of information and you will be taken off the mailing list.

If you are interested in receiving information or in joining one of these Disease Management Programs and have not been identified as an eligible Member by the Plan, you may contact us toll free to receive this information at 1-800-752-5863 or (605) 328-6800. More information is also available on these programs on our website at www.sanfordhealthplan.com.

CLAIMS PAYMENT PROCEDURE

CLAIMS PAYMENT PROCEDURES

A. HOW A MEDICAL CLAIM GETS PAID

1

You go to the doctor or facility to receive medical services and present your Sioux Valley Health Plan Identification Card.



2

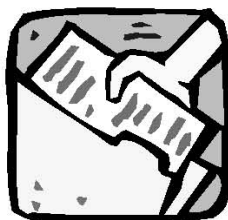
After your services are completed, your provider's office prepares a claim to send to SVHP for processing. You may also receive a statement from the provider at this time.



Participating providers may take up to 120 days to file a claim with SVHP. You may contact the provider's office to determine how quickly your claim will be submitted to SVHP.

3

Once SVHP receives a claim from your provider, the claim is processed for payment. SVHP pays 99% of all 'clean claims' in 30 days or less. Claim payments are generally made directly to the provider. "Clean claim" is a complete, written claim with all the required supporting information.



4

Once your claim is processed, an Explanation of Benefits is generated and mailed to your home address.



B. When to File a Claim

Upon providing services, all Participating Providers and most Non-Participating Providers will file a claim with the Plan for services rendered. The only time you will need to file a claim is if a Non-Participating Provider did not file one for you. The Plan must receive all claims within *one hundred twenty (120) days* of the date of service.

C. How to File a Claim

A separate claim form must be completed for each member of your family and for each Practitioner and/or Provider from whom medical services were received. You may obtain a claim form from your employer's Human Resources Department. Please contact your Human Resources Department or our Member Services Department at (605) 328-6800 or 1-800-752-5863 with any questions.

For pharmacy claims: If you do not utilize a Participating Pharmacy, except in an emergency, you are responsible for the full cost of the drug. If you fail to utilize your **prescription drug card**, except in an emergency, you are responsible for manually filing a paper claim with the Plan and must accept a reduced level of reimbursement. Reimbursement will be at the rate that would have been paid by the Health Plan had you used your ID card. If you must submit pharmacy claims, you may attach receipts for more than one pharmacy to the claim form as long as all prescriptions are for the same person.

You must complete all sections of the claim form and attach to the form a copy of the itemized statement from your Practitioner and/or Provider. The statement from the Practitioner and/or Provider must include the following information:

- Patient's name.
- Patient's member identification number.
- Date(s) you received service(s).
- Date of the injury or beginning of the illness.

- Charge for each service(s).
- Procedure codes for service(s) received.
- Diagnosis or type of illness or injury.
- Location where you received the service(s).

Please make sure you sign the form and include a daytime phone number where you can be reached to answer any questions. This information, along with your claim form and itemized statement(s) may be sent to Sanford Health Plan of Minnesota, P.O. Box 91110, Sioux Falls, SD 57109-1110.

Upon processing of the claim, you will receive a statement explaining your benefits (Explanation of Benefits – EOB) within *thirty (30)* days of receipt of the claim. Remember, we will settle directly with the Practitioner and/or Provider for services you received. You will then be responsible for paying any applicable amounts (this includes, but is not limited to, copay and deductible amounts).

D. Coordination of Benefits

In some cases, you may be covered by another insurance plan or HMO in addition to the Plan. If so, we will work with the other insurer to be sure you receive full benefits without paying for services twice. If you are covered by another insurance plan, please tell the Member Services Department so that we can find out whether another insurer may be responsible for paying for some of your care.

If your eligibility shifts to Medicaid or Medicare, please notify the Plan as soon as possible so that we may coordinate your benefits appropriately.

ONLINE ACCESS TO YOUR HEALTH INFORMATION

Digital Health Plan

Sanford Health Plan offers you a quick and easy way to view your claim activity and manage your health plan information 24 hours a day, 7 days a week through Digital Health Plan! Digital Health Plan is your online access to a variety of Member Services including:

- Finding a Participating Provider online;
- Adding and removing dependents to your health plan;
- Ordering replacement ID Cards;
- Viewing authorization and referral requests;
- Viewing your personalized benefit plans;
- Updating personal information such as you name and address; and
- Viewing your claims status through an online Evidence of Benefits (EOB);

The purpose of an EOB is to show the benefits coverage you or your covered family member received for the services billed to us by your health care Practitioner and/or Provider. The Explanation of Benefits lets you know the dollar amount of services that were billed by your Practitioner and/or Provider and how that amount is applied to deductible, coinsurance or copayments, or if any of the charges were for non-covered services.

Digital Health Plan is available to you and every dependent on your plan. To access Digital Health Plan, each member must sign up and register with Digital Health Plan using a username and password that is chosen by the member. Health information is kept confidential and secure through this registration process. To register today, simply go to www.sanfordhealthplan.com and click on “Digital Health Plan.”

PROVIDER REIMBURSEMENT

A. Reimbursement for Participating Providers

Participating Providers are under contract with the Plan, and will agree to accept the negotiated contracted amount as reimbursement for services provided to the Plan's members, and should not send you a bill for charges over these set fee schedules. However, you may be billed for any deductible, copayment, or coinsurance amounts that are not covered under your Plan. Office visit copayments are due at the time of service.

B. Physician Reimbursement

Physicians contracting with The Plan will be compensated under a fixed fee schedule that will be based initially on the Medicare Resource Based Relative Value System (RBRVS). This fee schedule is based on reasonable and customary charges for procedures performed in the regional market. Physicians and other non-facility providers under contract to the Plan will agree to accept this fee schedule as reimbursement in full for services provided to

the Plan's members. Physicians and other Practitioner and/or Providers not contracted with the Plan, accessed via the Out-of-Network provisions in the Plan will be paid according to a fee schedule based on usual and customary reimbursement (UCR) levels. This level will be established at the median level of physician charges - the 50th percentile. Non-contracted providers will have the right to collect from the members that portion of their fee not covered by the schedule.

C. Hospital Reimbursement

Hospitals and other facilities that provide services on an inpatient basis and who are under contract to the Plan will typically be paid on a per diem (per day) basis. These entities will agree to accept a maximum reimbursement per day based on the contract and will be prohibited from collecting additional reimbursement from the member. There will be occasional situations when the Plan will sign contracts with reimbursement agreements that include a discount from charges. These relationships are expected to represent a very minor portion of facility utilization.

Hospitals and other facilities that provide services on an outpatient basis, especially ambulatory surgery, and are under contract to the Plan will typically be paid a fixed fee based on ambulatory surgery groupings and similar methods. These entities will agree to accept a maximum reimbursement per service based on the contract and will be prohibited from collecting additional reimbursement from the member. There will be occasional situations when the Plan will sign contracts with reimbursement agreements that include a discount from charges. These relationships are expected to represent a very minor portion of this outpatient utilization.

MEMBER SATISFACTION PRINCIPLES

The Plan is committed to your satisfaction. One of the ways that we ensure that our services meet the needs of our members is to ask you how we and the providers in our network have been performing. We value what you say and we want to continue to improve our services. Therefore, as a member of our Plan, you may receive a survey from us at least once a year so that you can tell us how satisfied you are with the services you receive. You may also be asked to fill out a survey after an appointment with a Practitioner and/or Provider or you may periodically receive a telephone call from one of our Member Services Representatives. Your satisfaction is important to us.

We encourage you to call or write to us with your comments and concerns. Please feel free to contact our Member Services Department at 1-800-752-5863 or write to Sanford Health Plan of Minnesota, P.O. Box 91110, Sioux Falls, SD 57109-1110.

Adult members will also have an opportunity to express their opinions on matters of Plan policy and operations through member representation on the Board of Directors and participation in the Member Advisory Council.

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 Practitioner and/or 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.

A. 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
 - e. Continued care and services
3. Claims Denials – denials based on timely and accurate filing of claims and failure to request authorization of services.

B. Types of Appeals:

1. 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.

2. Expedited Appeal: A request to change a previous decision made by Sanford Health Plan for an urgent care request.
3. 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.

C. Definitions

Complaint: An oral or written expression of dissatisfaction against the Plan which has been submitted by a complainant and which is not under litigation. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and Practitioner and/or Provider complaints. A process has been established for Members (or their designees) and Practitioner and/or Providers to use when they are dissatisfied with the Plan, its Practitioner and/or Providers, or processes. Examples of complaints are the scope of coverage for health care services; eligibility issues; denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services provided.

Complainant: This is a Member, applicant, or former Member or anyone acting on behalf of a Member, applicant, or former Member, who submits a complaint.

Utilization Review: Means the evaluation of the necessity, appropriateness, and facilities used by a Member for the purpose of determining medical necessity of the service or admission.

D. Complaint & Medical Review Determination Process

1. **Informal Complaints**: A complainant may orally submit a complaint to the Member Services Department. Member Services will make every effort to resolve the complaint. The Member Services Department will investigate the complaint and provide for informal discussions. If the oral complaint is not resolved to the complainant's satisfaction within *ten (10)* business days of receipt of the complaint, the Plan will provide a complaint form to the complainant, which must be completed and returned to the Member Services Department for further consideration. The Plan will assist the complainant in completing this form, or will complete the form and mail it to the complainant for a signature, if the complainant asks for assistance.

At any time, the complainant may also file a complaint with the Commissioner of Health regarding network benefits, either in writing or by calling (651) 282-5600, or toll free 1-800-657-3916 or the Commission of Commerce regarding Supplemental (Out of Network) benefits at (651) 296-2488, or toll free at 1-800-657-3602.

2. **Formal/Written Complaint Process**: A complainant can seek further review of a complaint not resolved through the formal process. The steps in this complaint and appeal process are outlined below.

Formal Complaint Review. You or your authorized representative may send your written request for review, including comments, documents, records and other information relating to the complaint, the reasons you believe you are entitled to benefits and any other supporting documents to:

Sanford Health Plan of Minnesota
Member Services Department
PO Box 90447
Sioux Falls, SD 57109-0447

We will notify the complainant that we received the written complaint, unless the complaint has already been resolved to the complainant's satisfaction.

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your complaint.

We will review your complaint and notify you of our decision.

All notifications will comply with applicable State law and NCQA standards. Please refer to your Policy for more information.

E. Appeal Process

NOTE: FILING DEADLINE FOR APPEALS

When, due to a medical reason, an initial determination is made not to cover a health care service prior to or during an ongoing service, an appeal must be submitted to the Plan within 180 days following the written notice of initial determination.

1. Pre-service appeal (for utilization review for a medical determination).

If the Member or a Member's authorized representative appeals an adverse response, Members do not have the right to attend or have a representative attend the first level review, but Members are entitled to:

1. Send written comments, documents, records and other material relating to the request; and
2. Receive reasonable access to documents, records and other information relevant to the request, free of charge.

A full and thorough investigation of the substance of the appeal, including any aspects of clinical care, will be coordinated by the Complaint Coordinator. A person who was not involved in the initial determination nor the subordinate of any person involved in the initial determination will review the appeal. For medical necessity reviews only, a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the appeal. The Plan will document the substance of the appeal and any actions taken.

Expedited Appeal

An expedited appeal process is used when the condition is emergent or urgent in nature, as defined by the Policy.

An expedited review of a prior authorization (preservice) 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. For medical necessity reviews only, a practitioner in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the request.

All appeal determinations and notifications to the Member and their Practitioner and/or Provider are made by the Utilization Department within the timeframes required by State law and NCQA standards. Please refer to your Policy for more information on The Plan's procedures for timely handling of appeals and how to initiate the appeals process.

- 2. Post-service appeal.** If after the first level of complaint review of a post-service claim, your request was denied, you or your authorized representative may submit a written request for appeal either in writing or by telephone. Written requests should include any relevant documents, issues, comments and additional information as appropriate and be sent to:

Sanford Health Plan of Minnesota
Member Services Department
PO Box 90447
Sioux Falls, SD 57109-0447

The Member Services Department will provide the complainant with the option of either a written reconsideration, or a hearing before the Member Appeals Committee either in person or over the phone. Hearings and written reconsideration shall include the receipt of testimony, correspondence, explanations, or other information from the complainant, staff persons, administrators, providers, or other persons as deemed necessary for a fair appraisal and resolution of the complaint. During your appeal, upon you request we will provide you, free of charge, reasonable access to all documents, records and other information relevant to your appeal.

A full and thorough investigation of the substance of the appeal, including any aspects of clinical care, will be coordinated by the Complaint Coordinator. A person who was not involved in the initial determination nor the subordinate of any person involved in the initial determination will review the appeal. For medical

necessity reviews only, a Practitioner and/or Provider in the same or similar specialty that typically treats the medical condition, performs the procedure, or provides the treatment will review the appeal. The Plan will document the substance of the appeal and any actions taken.

We will review your appeal and written notice of the decision and all key findings will be given to the complainant within *thirty (30)* calendar days of the Member Services Department's receipt of the complainant's written notice of appeal. If a complainant appeals by hearing, written notice of the decision and all key findings will be given to the complainant within *forty-five (45)* calendar days of the Member Services Department's receipt of the complainant's written notice of appeal.

In certain circumstances, this time period may be extended *fourteen (14)* additional days. In such cases the Plan will notify you in advance, of the reasons for the extension.

F. External Reviews

An external review is a request for an independent, external review of the final determination made by Sanford Health Plan through an external appeals process.

1. If your complaint is denied based on our medical necessity criteria, you have the right to request an external review upon receiving notice of our decision on your complaint. If your complaint is denied for any other reason, you have the right to request external review upon notice of our decision at the completion of internal appeal process. However, if the complaint relates to a malpractice claim, the complaint shall not be subject to the internal appeal process.
2. To initiate the external review process, you may submit a written request for an external review to the Commissioner of Health (Commissioner of Commerce). This written request must be accompanied by a \$25 filing fee payable to the Center for Health Dispute Resolution. This fee may be waived by the Commissioner in cases of financial hardship. We must participate in this external review, and must pay the cost of the review which exceeds the \$25 filing fee.
3. Upon receipt of the request for external review, the external reviewer must provide immediate notice of the review to the complainant and to us. Within 10 business days, the Member and the Plan must provide their reviewer with any information they wish to be considered. The Member (who may be assisted or represented by a person of their choice) and the Plan shall be given an opportunity to present their versions for the facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.
4. An external review must be made as soon as possible, but no later than 40 calendar days after receipt of the request for external review. Prompt written notice of the decision and the reasons for it must be sent to the Member, the Commissioner of Health or Commissioner of Commerce, and to the Plan.
5. The results of the external review are non-binding on the Member and binding on the Plan. We may seek judicial review of the decision under certain circumstances.
6. Notification to Members about the independent, external appeal program includes a general communication to Members, at least annually, to announce the availability of the right to independent, external review.

TERMINATION OF COVERAGE

A. Voluntary Termination by the Subscriber

You may be allowed to voluntarily terminate coverage for you and/or any Dependents when the following events occur:

- During your Employer's annual Open Enrollment period;
- When your Employer makes changes to your existing Benefit Package(s);
- Upon a marriage or divorce; or
- Upon the birth or adoption of a dependent.

The Plan must receive a written request stating the date to end coverage. You 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.

You may elect continuation of coverage in some circumstances. Please see your Policy or call the Plan for more information.

B. Termination of Member Coverage

A Member, retiree, or dependent's coverage will automatically terminate at the earliest of the following events below. Such action by the Plan is called disenrollment.

1. Service Charge Payments - Failure to make any required service charge payments, copayments, deductibles or coinsurance when due. A grace period of *thirty-one (31)* days, unless otherwise stated in your 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. Employee Termination - The last day of the month in which date the Member's active employment with the Group is terminated is the date benefits will cease for the Member(s).
3. Group Termination - The date your Group terminates coverage.
4. Move Outside the Area - Coverage will terminate if you (with the exception of a Student Dependent) establish permanent residence outside the service area.
5. Contract Termination - This Contract terminates.
6. Eligibility - The last day of the month in which you are no longer eligible for coverage under this Contract.
7. Retiree Termination - The last day of the month in which the retiree, or his or her dependents become eligible for Medicare.
8. Death - The date the Member dies.
9. Lifetime Maximum - When lifetime maximum benefits of your Plan have been met.
10. Armed Forces - The first of the month following the date the Member enters the armed forces of any country as a full-time Member.
11. Use of ID Card by Another - The date you allow another individual to use your ID Card to obtain services.
12. Fraudulent Information - The date a member's application form contains false information.

You may not be disenrolled due to the status of your health or because you have exercised your rights under the Plan's policy on Member Complaints and Grievances and Appeal Procedures for Medical Review Determinations.

C. Notice 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 member, at least *thirty (30)* 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.

This 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 Plan at (605) 328-6800 or 1-800-752-5863 for information on the COBRA provisions.

D. Termination of Dependent Coverage

A dependent's coverage ends when the Subscriber's coverage ends. An enrolled dependent's coverage shall also end when the dependent no longer meets the following eligibility requirements:

1. Is unmarried;
2. Receives more than half of his or her support from the Subscriber; and
3. Is 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, 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. A student who is unable to carry what the school considers to be a full-time course load because of illness, injury or physical or mental disability as documented by a physician will be considered a full-time student for purposes of this Contract if the student's course load is *sixty (60)* percent of what the school considers to be a full-time course load; or
 - (c) a child incapable of 1) self-sustaining employment by reason of mental retardation, mental illness or disorder, or physical handicap and 2) chiefly dependent upon the Member for support and maintenance, provided proof of such incapacity and dependency is furnished to the Plan by the Member within 31 days of the child's attainment of the limiting age and subsequently as may be

required by the Plan but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

E. Notification Requirements

1. The Subscriber must notify the Plan of his or her employer within *sixty (60)* days of a divorce, legal separation, loss of dependent status and eligibility for the Social Security disability extension for COBRA coverage.
2. The Subscriber must notify the Plan within *thirty (30)* days of being notified of no longer being eligible for the Social Security disability extension.

F. Member Appeal of Termination

You may appeal the Plan's decision to terminate, cancel, or refuse to renew your coverage. Please refer to the Plan's policy on Member Complaints found in the *Member Complaints and Appeal Procedures* section of this Handbook or your Policy.

Pending the appeal decision, coverage will terminate on the date, which was set by the Plan. However, your coverage may continue, if you are entitled, by complying with the "continuation of coverage" provisions. If the Plan decides the appeal in your favor, coverage will be reinstated, retroactive to the effective date of termination, as if there had been no lapse in coverage.

G. Termination of the Group Health Maintenance Contract and Notice

The Plan may terminate the Group Health Maintenance Contract in accordance with the terms of the Group Health Maintenance Contract. Termination does not require the consent of members. Notice of termination will be sent to the Group and will state the effective date of termination.

In situations where The Plan is canceling coverage for all enrollees of a group plan due to the Group's nonpayment of the premium, The Plan will give all enrollees *thirty (30)* days notice of termination. The effective date of the notice shall not be less than 30 days after the notice date and shall clearly state the cancellation date which shall be no more than 60 days prior to the effective date of the notice. The notice will include a statement of the your rights to convert to an individual policy without underwriting restrictions and a telephone number to call for further information about conversion to an individual plan.