



An Individual Sanford Health Plan Product

INDIVIDUAL POLICY

Renewal Provision

We will refuse renewal of this policy only if we refuse renewal on all policies of this form and class or if you use this policy fraudulently. If we refuse to renew all policies of this form and class, we will give you *ninety (90)* days written notice prior to termination. In this event, you will have the option to purchase any other health insurance currently being offered by us to individuals with no additional underwriting.

To keep the policy in force, you must pay each premium on its due date or within the grace period. We may change the premium from time to time, but only if we change the premium for all policies of this form and class.

Right to Cancel and Return Your Policy

We want you to be satisfied with this policy. If you are not satisfied, you may cancel it within *ten (10)* days after receiving it by mail or delivering it to us. If returned, the policy will be considered void from the original effective date and we will refund any premiums paid. If we have paid claims for you during this inspection period, we have the right to recover any amounts we paid.

How to Contact Us

If you have any questions about provisions of this Policy, please write or call:

Sanford Health Plan
300 Cherapa Place, Suite 201
PO Box 91110
Sioux Falls, SD 57103
Phone: 1-877-305-5463



Sanford
Health Plan

WELCOME TO SANFORD HEALTH PLAN A South Dakota Insurance Company

Welcome to Sanford Health Plan (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.

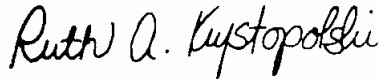
In exchange for your completed application, and payment of the premium as shown on your application, we will pay benefits of this policy according to its provisions.

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

Sanford Health Plan 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. Also, prevention and wellness programs are built into the benefit package. This encourages Members to seek treatment early and to live healthier lifestyles.

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. 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 Practitioners and/or 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.



Ruth A. Krystopolski
President
Sanford Health Plan

NOTICE OF PRIVACY PRACTICES

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

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

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

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

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

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

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

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

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

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

Communications With You. We may communicate with you regarding your claims, premiums, or other things connected with your health plan. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish messages to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. In considering reasonable requests, Sanford Health Plan may consider if disclosure of all or part of the

information would endanger the Member. You may request such confidential communication in writing and may send your request to Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110.

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

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

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

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

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

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your

representative. You may obtain an access request form from Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110.

Amendments to Your Personal Health Information. You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110.

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

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

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

FOR FURTHER INFORMATION

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

EFFECTIVE DATE

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

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INTRODUCTION

Member Rights

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

1. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race, color, religious creed, handicap, ancestry, national origin, age, sex or sources of payment for care.
2. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
3. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. Members have the right, but are not required, to select a Primary Care Physician (PCP) of their choice. If a Member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
5. 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 South Dakota law.
6. Members have the right to know the identity and professional status of individuals providing service to them and to know which Physician or other Provider is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
7. 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 Providers responsible for coordinating their care, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with Providers in decision making regarding their treatment planning.
8. Members have the right to give informed consent before the start of any procedure or treatment.
9. When Members do not speak or understand the predominant language of the community, the Plan will make its best efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
10. 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.
11. Members have the right to a clear grievance and appeal process for complaints and comments and to have their issues resolved in a timely manner.
12. Members have the right to appeal any decision regarding medical necessity made by the Plan and its Providers.
13. Members have the right to terminate from the Plan, in accordance with Plan guidelines.
14. Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
15. Members have the right to receive information about the organization, its services and Providers and members' rights and responsibilities.

Member Responsibilities

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

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 Provider. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
2. Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when telephoning or contacting the Plan.
3. Members are responsible for following all access and availability procedures.
4. Members are responsible for seeking emergency care at a Plan participating emergency Facility whenever possible. In the event an ambulance is used, direct the ambulance to the nearest participating emergency Facility unless the condition is so severe that you must use the nearest emergency Facility. State law requires that the ambulance

transport you to the Hospital of your choice unless that transport puts you at serious risk.

5. Members are responsible for notifying the Plan of an emergency admission as soon as reasonably possible and no later than forty-eight (48) hours after becoming physically or mentally able to give notice.
6. Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible Provider or the Hospital.
7. Members are responsible for following their treatment plan as recommended by the Provider 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 Provider's instructions.
9. Members are responsible for notifying the Plan within *thirty (30)* days at 1-800-752-5863 or (605) 328-6800 if they change their name, address, or telephone number.
10. Members are responsible for notifying The Plan of any changes of eligibility that may affect their membership or access to services.

Authorized Policy Changes

No agent, employee, or representative of The Plan is authorized to vary, add to, change, modify, waive or alter any of the provisions of this policy. This policy cannot be changed except by:

- Written amendment signed by one of our authorized officers and accepted by you as shown by payment of the premium. Your acceptance of the amendment must be in writing if the amendment:
 - reduces or eliminates benefits; or
 - increases benefits and is accompanied by an increase in premium during the policy term, unless the increase in benefits is required by law.
- Written amendment in which we exercise a right specifically reserved under this policy that is signed by one of our authorized officers and mailed to you and accepted by you as shown by payment of the premium.
- Our receipt of written notification that your marital or dependent status has changed and we receive an appropriate premium in advance, then we will change your coverage to the correct coverage type. See *Types of Coverage* explained in *Section 1*.

Governing Law

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

Incontestability

After this policy has been in effect for *two (2)* years, we will not void this policy for misstatements on your application (unless they are fraudulent misstatements) nor will we deny benefits because they relate to a disease or condition which existed prior to the effective date of this policy.

Physical Examination

We may, at our own expense, have a physician examine you when and as often as we may reasonably require during the pendency of a claim under this policy.

Legal Action

You may not start legal action regarding a claim that we have denied under this policy unless you have exhausted the appeal process described in Section 7: *Problem Resolution*.

No legal or equitable action may be brought against us because of a claim under this policy, or because of the alleged breach of this policy, more than *three (3)* years after written proof of loss is required to be furnished.

Disclosure Statement

You hereby expressly acknowledge your notice that this policy is a contract solely between you, the plan member, and us, Sanford Health Plan. You, the policyholder, further acknowledge and agree that you have purchased this policy based upon representations by us or our authorized representatives. No other person, entity, or organization other than us is accountable or liable to you for any obligations created under this policy. This paragraph does not create any additional obligations whatsoever on our part other than those obligations created under the provisions of this policy.

Conformity with State Statutes

On the effective date of this policy, if any provision of this policy is in conflict with the statutes of the state in which the policyholder resides, then this policy will be amended to conform to the minimum requirements of such statutes.

Service Area

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

Medical Terminology

All medical terminology referenced in this Policy follow the industry standard definitions of the American Medical Association.

SECTION 1. ENROLLMENT

Types of Coverage

IMPORTANT INFORMATION: The terms of your coverage are defined in the documents that make up your contract. Your contract includes any application or underwriting documents you submitted to us, this benefits policy, and any riders or amendments. All of the statements made by you in any of these materials will be treated by us as representations, not warranties.

There are three different types of coverage you may hold under this policy.

1. *Single* coverage means the policyholder is the only one covered.
2. *Individual + One* means this policy covers two people in any of the following combinations:
 - a. the policyholder and his or her spouse;
 - b. the policyholder and a dependent child; or
 - c. *two (2)* eligible, dependent children.
3. *Family* coverage means the policyholder, his or her spouse and each of his or her eligible, dependent children has coverage. Each covered family member must be listed on the policyholder's application for coverage or added later as a new covered person.

Premiums

You must pay us in advance each calendar month for the duration of your policy. The payment must meet the premium requirements for that month.

Grace Period.

A grace period of *thirty-one (31)* days, following the premium payment due date will be allowed for the payment of any premium after the first fee is paid. During this time, coverage will remain in force. If the premium is not paid on or before the end of the grace period, coverage will terminate at the end of the grace period. We may, however, deduct the applicable premium amount from any claims we pay during the grace period.

Reinstatement. If you fail to pay any monthly renewal premium within the *thirty-one (31)* day grace period, your coverage will lapse. You may request reinstatement of this policy by submitting an application for reinstatement to us. We may approve or disapprove your application. You will be notified by us in writing of our decision on your application for reinstatement. If we do not notify you of our disapproval within 45 days of the date you submitted your application for reinstatement to us, this policy will be reinstated upon the 45th day following our receipt of your application for reinstatement. If reinstated, this policy will only cover claims for services that occurred after the date of reinstatement.

Premium Changes. We have the right to change your premium upon our implementation of a new table of rates or an increase in your age. If we do change your premium, we will notify you at least *thirty (30)* days before the change.

Term and Renewal

This policy will be in force for one month after the effective date, provided we have received and accepted your application and payment. If premium is paid within the grace period and your policy is not terminated by you or by us, then we will automatically renew your policy each month.

When Coverage Begins

Your policy becomes effective at 12:00 a.m. (midnight), Central Standard Time, on the date shown on your application and your enrollment letter. Coverage begins on the day your policy goes into effect unless you are in the hospital or other inpatient facility. In that case, your coverage begins the day after your discharge from the hospital or other inpatient facility.

NOTE: Before you receive benefits under this policy, you have agreed in your application to release any necessary information requested about you so we can process claims for benefits. You must allow any provider, facility, or their employee to give us information about a treatment or condition. If we do not receive the information requested, or if you withhold information in your application, your benefits may be denied.

If you misrepresent or conceal material facts in your application, then we may terminate this policy at any time during the first two years of coverage. If you fraudulently use your policy, we may terminate this policy at any time.

Eligibility Requirements for Dependents

The following Dependents are eligible for coverage (“Dependent coverage”):

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

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

1. Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child;
2. Be unmarried; and
3. Be one of the following:
 - a. under nineteen (19) years old; or
 - b. under twenty-five (25) years old and enrolled in and attending an accredited college, university, or trade or secondary school on a full-time basis. For the purpose of the Plan, the school’s definition of “full-time student” shall be used to determine if a Dependent is a full time student.; or
 - c. incapable of self-sustaining employment and Dependent on her or his parents or other care Providers for lifetime care and supervision because of a disabling condition that was present before the child was nineteen (19) (or twenty-five (25), if a full-time student). If the Plan so requests, the Subscriber must provide proof of the child’s disability within *thirty-one (31)* days of the Plan’s request.

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

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

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

Qualified Medical Child Support Order (QMCSO) Provision

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

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

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

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

Exceptions. If a court has ordered a Subscriber to provide health coverage for a Dependent Child, the above requirements in the *Dependent Child*, Sections 1-3 above, need not be satisfied, but the Subscriber must still request enrollment on behalf of the Dependent Child as set forth in this Plan. If the Subscriber fails to enroll the Dependent Child, the other parent may enroll the Dependent Child. A Dependent Child who is provided coverage pursuant to this exception shall not be terminated unless the Plan is provided satisfactory written evidence of any of the following:

1. The court or administrative order is no longer in effect; or
2. The Dependent Child is or will be enrolled in comparable health coverage through an insurer which will take effect not later than the effective date of the termination.

Coverage Changes

The following events may require or allow you to remove family members from your coverage:

1. Active Duty in the military of a spouse or dependent child;
2. Completion of full-time schooling of a dependent;
3. Death;
4. Dependent child who *is not* a full-time student or permanently disabled reaches age 19;
5. Divorce, annulment, or legal separation;
6. A change in residency or a move outside of the service area; and
7. Marriage of a dependent child.

You must notify us within *thirty-one (31)* days of the date of the event changing coverage.

When and How Dependent Coverage Begins

When to Enroll Dependents

Certain events may require you to change who is covered by this policy. The following events allow you to add the person directly affected by the event as well as a spouse or any eligible children:

- a. Appointment as a legal guardian of a child;
- b. Birth or adoption of a child;
- c. Care of a foster child (when placed in your home by an approved agency);
- d. Marriage, which permits adding the new spouse and the new spouse's children;
- e. Removal of Covered Persons under this policy; and
- f. A dependent resumes full-time student status

How to Enroll Dependents

A Subscriber must:

- Agree to pay the required additional premium, if any;
- Complete and sign the Plan's enrollment application form requesting coverage for the Dependent(s); and
- Receive approval from medical underwriting (if applicable).

When Dependent Coverage Begins

1. General

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

2. Delayed Effective Date of Dependent Coverage

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

IMPORTANT INFORMATION: Notification of birth or adoption is required within *thirty-one (31)* days to establish coverage.

3. Coverage from Birth

If a Subscriber has a child through birth, the child will become a covered Dependent from the moment of birth, provided that coverage is applied for the child and the required Premium payments are made within *thirty-one (31)* days from the date of birth. The newborn will be added to this policy without health underwriting and is not subject to the preexisting condition waiting period.

4. Adoption or Children Placed for Adoption

If a Subscriber, adopts a child or has a child placed with him or her as a Dependent, that child will become covered as a legal Dependent from the date of adoption or beginning of the *six (6)* month adoption bonding period, as noted in the legal adoption papers, provided that coverage is applied for the child within *thirty-one (31)* days from the date of adoption or the beginning of the *six (6)* month adoption bonding period and the required Premium payments are made. The adopted child will be added to this policy without health underwriting and is not subject to the preexisting condition waiting period.

5. New Spouses and Dependent Children

If a Subscriber gets married, his or her Spouse and any of the Spouse's Dependents who become Eligible Dependents of the Subscriber as a result of the marriage may become covered without being subject to underwriting or a pre-existing condition waiting period from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for the Spouse and/or Dependent within *thirty-one (31)* days of the date of marriage and the required premium payments are made. If the Spouse and Dependent Children are not added to this policy within *thirty-one (31)* days of the date of marriage, the Spouse and Dependent will be subject to health underwriting and the Pre-Existing Condition waiting period.

SECTION 2. HOW COVERAGE ENDS

Termination of Coverage

Upon coverage changes as described in *Section 1*, you may be allowed to terminate coverage for you and/or any Dependent(s). The Plan must receive a written notice from you to end coverage. The Subscriber will be responsible for any premiums through the date of termination. Your eligibility for coverage will terminate at 11:59pm, Central Standard Time, on the last day of the month for any of the following events:

1. **Premium Payments.** Failure to make any required premium payments by the end of the grace period.
2. **Written Request for Termination.** You give us written notice of termination not less than *thirty (30)* days in advance. We will refund any premium you have prepaid following the month of termination.
3. **Contract Termination.** We decide to terminate coverage of all similar policies by giving written notice to you *ninety (90)* days prior to termination. In this event, you will have the option to purchase any other health insurance coverage currently being offered by us to other individuals with no additional underwriting.
4. **Eligibility.** You become ineligible for coverage under this policy. See “Coverage Changes” in *Section 1*.
5. **Lifetime Maximum.** When lifetime maximum benefits of The Plan have been met.
6. **Fraudulent Information or use of ID card by another.** You use this policy fraudulently or you fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payments we made, minus any premiums paid.
7. **Change in residency or move out of the service area.** You become ineligible for this policy once you have established residency outside of South Dakota or have lived outside of the service area for more than ninety (90) consecutive days. Members must maintain a street address in South Dakota.

Notice of Creditable Coverage

A Certificate of Creditable Coverage will automatically be sent to you and your covered family Members upon your voluntary or involuntary termination from the Plan. You may also request a Certificate of Creditable Coverage at any time by calling the Member Service Department at (605) 328-6800 or toll free at 1-800-752-5863. Written requests can be emailed to MemberServices@sanfordhealth.org or directed to:

Sanford Health Plan
Attn: Member Service Department
PO Box 91110
Sioux Falls, SD 57109-1110

Effects of Termination

If your policy is terminated for fraud, misrepresentation, or the concealment of material facts:

- The Plan will not pay for any services or supplies provided after the date the policy is terminated.
- The Plan will retain legal rights; this includes the right to initiate a civil action based on the fraud, concealment, or misrepresentation.
- The Plan may, at our option, declare the policy void.

If your policy is terminated for reasons other than fraud, concealment, or misrepresentation of material facts, we stop payment for any services or supplies the day your policy is terminated. An exception to this applies only when you receive benefits as an inpatient of a hospital or as a resident of a nursing facility on the date the policy terminates. However, payment for inpatient benefits is limited to the least of the following:

- A period equal to your remaining days of coverage under this policy.
- A period ending on the date you are discharged from the hospital or nursing facility.
- A period not more than *sixty (60)* days from the date the policy is terminated.

SECTION 3. HOW YOU GET CARE

Identification cards

The Plan will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Provider, a healthcare facility, or fill a prescription at a Plan pharmacy. Your coverage will be terminated if you use your ID card fraudulently or allow another individual to use your ID card to obtain services.

If you do not receive your ID card within *thirty (30)* days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-752-5863 or write to us at PO Box 91110 Sioux Falls, SD 57109-1110. You may also request replacement cards through our website at www.sanfordhealthplan.com

Preconditions for Coverage

Members shall be entitled to coverage for the Health Care Services (listed in the “*Covered Services*,” in Section 4) that are:

1. Medically Necessary and/or Preventive; and
2. Received from or provided under the orders or direction of a Participating Provider, or approved by the Plan. However, this specific condition does not apply for Emergency Conditions or urgent care in and out of the Service Area. In such cases, the services will be covered if they are provided by a Non-Participating Provider. However, if Member is in the Service Area and is alert and oriented (as documented in medical records), Member must direct ambulance to the nearest Participating Provider.

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

In addition, all Health Care Services are subject to:

1. The exclusions and limitations described in Section 4; and
2. Any applicable Copay, Deductible, and Coinsurance amount as stated in the Summary of Payment in this Policy.

In Network Coverage

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

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

For Out-of-Network coverage, please see Section 4 (g).

In Network Coverage means Covered Services that are either received:

- a. from a Participating Provider;
- b. in an Emergency Medical Condition or an urgent care situation;
- c. when the Member does not have appropriate access (as defined below) 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

Primary Care Physicians and Hospital Providers

Appropriate access for Primary Care Physicians and Hospital Provider sites is within *thirty (30)* miles of a Member’s city of residence.

Specialty Providers

For other Participating Providers such as Specialty Physicians, Diagnostic Service Centers, Nursing Homes, Rehabilitation Providers, and Mental Health/Substance Abuse Providers, appropriate access is within *ninety (90)* miles of a Member’s city of residence. Appropriate access includes access to Participating Providers when the Member has traveled outside of the Service Area. If you are traveling within the Service Area where other Participating Providers are available then you must use Participating Providers.

Members who live outside of the Plan's Service Area must use the Plan's contracted Network of Participating Providers as indicated on the *Member Welcome Letter* attached to the Member Identification Card. Members who live outside the Service Area will receive Identification Cards that display their network logo along with instructions on how to access this Network. If a Member chooses to go to a Non-Participating Provider when access is available, claims will be processed at the Out-of-Network Benefit Level.

Transplant Services

Transplant Services must be performed at designated Plan Participating *Centers of Excellence* or Plan approved facilities and is not subject to Appropriate Access standards as outlined above. Transplant coverage includes related post-surgical treatment, drugs, eligible travel, and living expenses and shall be subject to and in accordance with the provisions, limitations and terms of the Plan's Transplant policy.

Utilization Review Process

The Plan's Utilization Management Department is available between the hours of 8:00am and 5:00pm Central Time, Monday through Friday, by calling the Plan's 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 Management Department and someone will return your call. The date of receipt for non-urgent requests received outside of normal business hours will be the next business day. The date of receipt for urgent requests will be the actual date of receipt, whether or not it is during normal business hours. All Utilization Management Adverse Determinations will be made by the Sanford Health Plan Medical Director or appropriate Practitioner.

• Prospective (pre-service) Review of Services (Certification/Prior Authorization)

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

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

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

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

1. Acute care hospitalizations (including medical, surgical, and obstetric admissions);
2. Psychiatric hospitalizations;
3. Rehabilitation center admissions; and
4. Chemical dependency admissions.

See "*Services that Require Prospective Review*" below.

Urgent Care Requests

In determining whether a request is "urgent," the Plan shall apply the judgment of a Prudent Layperson as defined in Section 10. A Physician, with knowledge of the Member's medical condition, who determines a request to be "urgent" as defined in Section 10 shall be treated as an Urgent Care Request.

• Services that Require Prospective Review/Prior Authorization (Certification)

1. Inpatient Hospital admissions including admissions for medical, surgical, neonatal intensive care nursery, mental health and chemical dependency services;
2. Partial Hospital Program (PHP)/Day Treatment for mental health;
3. Selected Outpatient Procedures;
4. Home Health, Hospice and Home IV therapy services;
5. Select Durable Medical Equipment (DME). See DME requiring Certification in section 4 (a);
6. One to one water therapy;
7. Skilled nursing and sub-acute care;
8. Transplant Services;
9. Referrals to Non-Participating Providers which are recommended by Participating Providers. Certification is required for the purposes of receiving In-Network coverage only. If Certification is not obtained for referrals to Non-Participating Providers, the services will be covered at the Out-of-Network Benefit Level. Certification does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in Section 2; and
10. PET Scans.

• Prospective Review Process (Non-urgent Pre-service) for Elective Inpatient Hospitalizations, Non-Urgent Medical and Behavioral Health Care Pharmaceutical and Benefit Requests

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

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

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

You are ultimately responsible for obtaining authorization (Certification) from the Utilization Management Department. Failure to obtain Certification will result in a reduction to the Out-of-Network benefits level. However, information provided by the Physician's office also satisfies this requirement.

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

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

Lack of Necessary Information

If the Utilization Management Department is unable to make a decision *due to lack of necessary information*, it must notify the Member or the Member's Authorized Representative of what specific information is necessary to make the decision *within fifteen (15) calendar days* of the Prospective (pre-service) Review request. Sanford Health Plan must give the Member or the Member's Authorized Representative *forty-five (45) calendar days* to provide the specified information. In lieu of notifying the Member, the Plan can notify the Practitioner and/or Provider of the information needed if the request for healthcare services came from the Practitioner and/or Provider. The decision time period is suspended from the date of the notification to the Member or Practitioner and/or Provider as applicable, until the earlier of the date on which the Plan receives any information from the Member or Practitioner and/or Provider or *forty-five (45) days* after the notification to the Member or Practitioner and/or Provider. The Prospective (pre-service) Review determination shall either be Certification of the requested service or additional review will be needed by the Plan Medical Director, however, the decision will be made *within fifteen (15) calendar days* of that date. If the information is not received by the end of *the forty-five (45) calendar day extension* Sanford Health Plan will deny the request. If the Plan receives a request that fails to meet the procedures for prospective review requests, the Plan will notify the Practitioner and/or Provider or Member of the failure and proper procedures to be followed as soon as possible but no later than *five (5) calendar days* after the date of the failure. Notification may be oral unless the Practitioner or Member request written notification.

Sanford Health Plan will give written or electronic notification of the *determination to certify or deny* the service *within fifteen (15) calendar days* of the request (or in the case of an extension, of the end of the time frame given to provide information) to the Member, or the Member's Authorized Representative, attending Practitioner and/or Provider and those Providers involved in the provision of the service. The Utilization Management Department will assign an authorization number for the approved service.

If the Plan's determination is an Adverse Determination, the Plan shall provide written notice in accordance with the *Written Notification Process for Adverse Determinations* procedure below. At this point, the Member can request an appeal of Adverse Determinations. Refer to "Problem Resolution" in Section 7 for details.

• Prospective (pre-service) Review Process for Urgent/Emergency (Urgent Pre-service) Medical and Behavioral Health Care and Pharmaceutical Requests

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

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

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

If an urgent care situation occurs, Members should contact their Primary Care Physician immediately, if one has been selected, and follows his or her instructions. A Member may always go directly to a participating urgent care or after hour's clinic. In determining whether a request is "urgent," the Plan shall apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. A Practitioner and/or Provider, with knowledge of the Member's medical condition, who determines a request to be "urgent" shall be treated as an urgent care request.

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

For urgent care Prospective (pre-service) Review, the determination will be made by the Utilization Management Department as soon as possible, but no later than *seventy-two (72) hours* after receipt of the request. Notification of the determination will be made to the Member, Practitioner and those Providers involved in the provision of the service via telephone by the Utilization Management Department as soon as possible but no later than *within seventy-two (72) hours* of receipt of the request. For authorizations (Certifications) and Adverse Determinations, the Plan will give electronic or written notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service as soon as possible but no later than *within three (3) calendar days* of the telephone notification. Adverse Determination

Lack of Necessary Information

If the Health Plan is unable to make a decision due to lack of necessary information, it may extend the decision time frame once for up to *forty-eight (48) hours* to request additional information. Within *twenty-four (24) hours* after receipt of the request, the Plan will notify the Member or the Member's Authorized Representative of what specific information is necessary to make the decision. In lieu of notifying the Member, the Plan can notify the Practitioner and/or Provider of the information needed if the request for healthcare services came from the Practitioner and/or Provider.

Sanford Health Plan must give the Member or the Member's Authorized Representative at least *forty-eight (48) hours* to provide the specified information. If the Plan receives a request that fails to meet the procedures for urgent prospective review requests, the Plan will notify the Practitioner or Member of the failure and proper procedures to be followed as soon as possible but no later than *twenty-four (24) hours* after the date of the failure. Notification may be oral unless the Practitioner or Member request written notification.

The Member, or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service will be notified by telephone of the Plan's determination as soon as possible but no later than *forty-eight (48) hours* after the earlier of 1) the Plan's receipt of the requested information or 2) the end of the period provided to submit the requested information. The Plan will also give electronic or written notification of the decision as soon as possible but no later than within *three (3) calendar days* of the telephone notification. Failure to submit necessary information is grounds for denial of authorization (Certification).

If the Plan's determination is an Adverse Determination, the Plan shall provide written notice in accordance with the *Written Notification Process for Adverse Determinations* procedure below. At this point, the Member can request an appeal of Adverse Determinations. Refer to "Problem Resolution" in Section 7 for details.

Concurrent Review Process for Medical and Behavioral Health Care Requests

Concurrent Review 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 levels of care criteria are not met, a decision to certify further treatment must be made at that time. Authorization (Certification) of Hospital or behavioral healthcare stays will terminate on the date the Member is to be discharged from the Hospital or behavioral healthcare Facility (as ordered by the attending Physician). Hospital/Facility days accumulated beyond ordered discharge date will not be certified unless the continued stay criteria continue to be met. Charges by Practitioner and/or Providers associated with these non-certified days will be considered non-covered.

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

Any reduction or termination by the Plan during the course of treatment before the end of the period or number treatments shall constitute an Adverse Determination. For requests to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least *twenty-four (24) hours* prior to the expiration of the prescribed period of time or number of treatments, the Plan shall make a determination and notify the Member, or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service by telephone of the determination as soon as possible taking into account the Member's medical condition but in no event more than *twenty-four (24) hours* after the date of the Plan's receipt of the request. The Plan will provide electronic or written notification of an authorization (Certification) to the Member, Practitioner and those Providers involved in the provision of the service within *three (3) calendar days* after the telephone notification. The Plan shall provide written or electronic notification of the Adverse Determination to the Member and those Providers involved in the provision of the service sufficiently in advance (but no later than within *three (3) calendar days* of the telephone notification) of the reduction or termination to allow the Member or, the Member's Authorized Representative to file a Grievance request to review of the Adverse Determination and obtain a determination with respect to that review before the benefit is reduced or terminated. In cases where the Member is not at financial risk, Members will not be notified of an Adverse Determination. Members will be notified in all other cases.

Urgent Concurrent Reviews

If the request to extend urgent Concurrent Review is not made at least *twenty-four (24) hours* prior to the expiration of the prescribed period of time or number or treatments, Sanford Health Plan will treat it as an urgent Prospective (pre-service) Review decision and make the decision within *seventy-two (72) hours* of receipt of the request. For authorizations (Certifications) and denials, the Plan will give telephone notification of the decision to Members, Practitioners and those Providers involved in the provision of the service within *seventy-two (72) hours* of receipt of the request. The Plan will give written or electronic notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service as soon as possible but no later than within *three (3) calendar days* of the telephone notification.

If the Plan's determination is an Adverse Determination, the Plan shall provide written notice in accordance with the *Written Notification Process for Adverse Determinations* procedures outlined below. At this point, the Member can request an appeal of Adverse Determinations. Refer to the "Grievance Procedures" in Section 7 for details.

Retrospective (post-service) Review Process for Medical and Behavioral Health Care

"Retrospective (post-service) review" means any review of a request for a benefit that is not a Prospective (pre-service) Review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication for payment. Retrospective (post-service) 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. Written or electronic notification will be made to the Member, Practitioner and those Providers involved in the provision of the service within *thirty (30) calendar* days of receipt of the request. In cases where the Member is not at financial risk, Members will not be notified of an Adverse Determination. Members will be notified in all other cases.

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

Lack of Necessary Information

If the Utilization Management Department is unable to make a decision due to lack of necessary information, it must notify the Member or the Member's Authorized Representative of what specific information is necessary to make the decision within *thirty (30) calendar* days of the retrospective (post-service) review request. Sanford Health Plan must give the Member or the Member's Authorized Representative *forty-five (45)* calendar days to provide the specified information. In lieu of notifying the Member, the Plan can notify the Practitioner and/or Provider of the information needed if the request for healthcare services came from the Practitioner and/or Provider. The decision time period is suspended from the date of the notification to the Member, Practitioner or Provider as applicable, until the earlier of the date on which the Plan receives any information from the Member, Practitioner or Provider or *forty-five (45)* days after the notification to the Member, Practitioner or Provider. A decision and written or electronic notification to the Member, Practitioner and those Providers involved in the provision of the service will be made within *fifteen (15)* calendar days of that date. If the information is not received by the end of the *forty-five (45)* calendar day extension Sanford Health Plan will issue an Adverse Determination and written or electronic notification will be made to the Member, Practitioner and those Providers involved in the provision of the service within *fifteen (15)* calendar days.

If the Plan's determination is an Adverse Determination, the Plan shall provide written notice in accordance with the *Written Notification Process for Adverse Determinations* procedure below. At this point, the Member can request an appeal of Adverse Determinations. Refer to the "Grievance Procedures" in Section 7 for details.

Written Notification Process for Adverse Determinations

The written notifications for Adverse Determinations will include the following:

1. The specific reason for the Adverse Determination in easily understandable language;
2. Reference to the specific plan provision, guideline, or protocol on which the determination was based and notification that the Member will be provided a copy of the actual plan provisions, guidelines, and protocols free of charge upon request;
3. If applicable, a description of any additional material or information necessary for the Member to complete the request, including an explanation of why the material is necessary;
4. If the Adverse Determination is based on a medical necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of The Plan to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
5. A written statement of clinical rationale, including clinical review criteria used to make the decision if applicable;
6. A description of the Plan's Grievance procedures including how to obtain an expedited review if necessary and any time limits applicable to those procedures; and
7. Notification and instructions on how the Practitioner and/or Provider can contact the Physician, appropriate behavioral health Practitioner (for behavioral health reviews) to discuss the determination.

To contact the SD Division of Insurance at any time at: SD Dept. of Revenue & Regulation, Division of Insurance, 445 East Capitol Avenue, Pierre, SD 57501-3185, Fax: (605) 773-5369, Phone: (605) 773-3563

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SECTION 4(A) MEDICAL SERVICES AND SUPPLIES PROVIDED BY PHYSICIANS AND OTHER HEALTH CARE PROFESSIONALS

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

- This policy, including your application for coverage and any riders or amendments constitutes your entire contract of insurance.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 2, *How to get care*, for valuable information about conditions for coverage.
- You or your Physician must get Certification of some services in this Section. The benefit description will say “NOTE: Certification is required” for certain services. Failure to get Certification will result in a reduction or denial of benefits (See Services requiring Certification in Section 2.)

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Benefit Description

Diagnostic and treatment services

Professional services from Physicians, nurse practitioners, and Physician’s assistants:

In Physician’s office, an urgent care center, medical office consultations, and second surgical opinions

NOTE: You or your Physician must get Certification of these services; Failure to get Certification will result in a reduction or denial of benefits (See Services requiring Certification in Section 2.):

- Inpatient hospital stays, Outpatient surgical procedures, and Skilled nursing facility stays

Lab, X-ray and other diagnostic tests

Such as:

Blood tests

Urinalysis

Non-routine pap tests

Non-routine PSA tests

Pathology

X-rays

PET Scans – NOTE: PET Scans require Certification

DEXA Scans

Non-routine mammograms

CT Scans/MRI

Ultrasound

Electrocardiogram (EKG)

Electroencephalography (EEG)

Preventive care, adult

As outlined in the Plan Preventive Health Guidelines

Periodic preventive physical examinations including periodic diagnostic procedures (limited per Plan guidelines), laboratory testing, diagnostic imaging and Plan Certified health education services for disease prevention and identification

Routine Immunizations

Medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness

Not covered:

- *Physical examinations, including but not limited to: school physicals, sports physicals, pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver’s licenses)*
- *Virtual colonoscopies*

FOR WOMEN ONLY

Routine Mammogram

- One baseline mammogram between the ages of 35-39
- One mammogram every year for ages 40 and older
- Screenings may be more frequent if there is a family history of breast cancer or as approved by the Plan

Routine Pap Test

- Annual gynecological exam examination includes a pap smear test
-

FOR MEN ONLY

Prostate Screening

- One prostate cancer screening every year for men:
 - Ages 50 and older; and
 - Ages 40 and older who are symptomatic or in a high risk category
 - For males of any age who have a prior history of prostate cancer, medically indicated diagnostic testing at intervals recommended by a physician, including the digital rectal examination, prostate-specific antigen test, and bone scan
-

Preventive care, children

As outlined in the Plan Preventive Health Guidelines

Pediatric Preventive visits including periodic examinations, laboratory testing (limited per Plan guidelines), diagnostic imaging (limited per Plan guidelines) and Plan Certified health education services for disease prevention and identification. For children through age six (6) years old, benefits shall be provided at the following age intervals: 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, 5 years and 6 years.

Limited diagnostic procedures and laboratory testing for children between the ages of 7-18

Routine Immunizations

Medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness

Not covered: Physical examinations, including but not limited to: school physicals, sports physicals, pre-employment and employment physicals

Allergy care

Testing and treatment

Allergy injections

Allergy serum

Not covered: Provocative food testing and sublingual allergy desensitization

Diabetes supplies, equipment, and education

- Blood glucose monitors
- Blood glucose monitors for the legally blind
- Test strips for glucose monitors
- Urine testing strips
- Insulin injection aids
- Lancets and lancet devices
- Insulin pumps and all supplies for the pump
- Custom diabetic shoes and inserts limited to *one (1) pair* of depth-inlay shoes and *three (3) pairs* of inserts; or *one (1) pair* of custom molded shoes (including inserts) and *two (2)* additional pairs of inserts
- Syringes
- Insulin infusion devices
- Prescribed oral agents for controlling blood sugars
- Glucose agents
- Glucagon kits
- Insulin measurement and administration aids for the visually impaired and other medical devices for the treatment of diabetes
- Routine foot care including toe nail trimming

Diabetes self management training and education shall be covered if:

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

Coverage of diabetes self-management training is limited to:

- persons who are newly diagnosed with diabetes or have received no prior diabetes education;
- persons who require a change in current therapy;
- persons who have a co-morbid condition such as heart disease or renal failure; or
- persons whose diabetes condition are unstable

Under these circumstances, no more than *two (2)* comprehensive education programs per lifetime and up to *eight (8)* follow-up visits per year will be covered. Coverage is limited to the closest available in-Network qualified education program that provides the necessary management training to accomplish the prescribed treatment.

Not covered: food items for medical nutrition therapy

Dialysis

Dialysis for renal disease, unless or until the Member qualifies for federally funded dialysis services under ESRD. Services include equipment, training, and medical supplies required for effective dialysis care. Coordination of Benefit Provisions apply, see Section 8.

Not covered: home hemodialysis, dialysis services received by Non-Participating Providers when traveling out of the Service Area

Treatment therapies

Inhalation Therapy

Radiation Therapy

Chemotherapy, regardless of whether the Member has separate prescription drug benefit coverage

Pheresis Therapy

Physical, cardiac, speech and occupational therapies

Outpatient Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitative services directed at improving physical functioning of the Member) which is expected to provide significant improvement within *two (2)* months, as certified on a prospective and timely basis by the Plan.

Coverage is limited to *thirty (30)* visits per therapy per Calendar Year

One-to-one water therapy

NOTE: Certification is required for One-to-one Water therapy; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 2.)

Not covered:

- *Services provided in the Members' home for convenience, that are not expected to make measurable or sustainable improvement within a reasonable period of time including therapy for chronic and/or recurring symptoms including but not limited to arthritis, back pain, and fibromyalgia*
- *hot/cold pack therapy including polar ice therapy and water circulating devices*
- *traction services*

Phenylketonuria

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

Not covered: PKU dietary desserts and snack items

Hearing services (testing, treatment, and supplies)

We cover diagnostic testing and treatment of illness or injury only

Not covered:

- *Routine hearing exams and services*
- *Adult hearing screening services, testing and supplies*
- *Hearing aids*
- *Cochlear implants and any related services*
- *Tinnitus Maskers*
- *All other hearing related supplies, purchases, examinations, testing or fittings*

Vision services (testing, treatment, and supplies)

Eyeglasses or contact lenses for aphakia patients or soft contact lenses or scleral shells intended for the use in the treatment of a disease or injury

Eyeglasses, including lenses and one frame per lifetime up to \$200 or clear contact lenses for the aphakic eye will be covered for *two (2)* single lens per calendar year

Scleral Shells: Soft shells limited to *two (2)* per calendar year. Hard shells limited to *one (1)* per lifetime

Not covered:

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

Foot care

Routine foot care for diabetics per Plan policy

Note: See Section on *Orthopedic and prosthetic devices* for information on podiatric shoe inserts

Not covered:

- *Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized corrective surgery (except as stated above)*
- *Diagnosis and treatment of weak, strained, or flat feet*

Orthotic and prosthetic devices

Prosthetic limbs, sockets and supplies, and prosthetic eyes limited to *one (1)* per lifetime

Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Includes *two (2)* external prosthesis per Calendar Year and *two (2)* bras per Calendar Year. For double mastectomy: coverage extends to *four (4)* external prosthesis per Calendar Year and *two (2)* bras per Calendar Year.

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

Devices that are permanently implanted that are not Experimental or Investigational such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy.

NOTE: Internal prosthetic devices are paid as Hospital benefits; see Section 4(b) for payment information. Insertion of the device is paid under the surgery benefit.

Not covered:

- *Cochlear implants and related services*
- *Revision/replacement of prosthetics (except as noted per Plan policy)*
- *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*
- *Wigs, cranial prosthesis, or hair transplants*
- *Cleaning and polishing of prosthetic eye(s)*

Durable medical equipment (DME)

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

Casts, splints, braces, crutches and dressings for the diagnosis of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Plan policy.

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

- Respiratory equipment such as ventilators, oxygen concentrators, pleural catheters, hand-held battery operated nebulizers, and suction pumps
- Gastrointestinal equipment such as TPN enteral supplies and formula, parenteral nutrition, and suction pumps
- Beds such as Hospital beds and mattresses
- Musculoskeletal equipment such as TENS units, neuromuscular stimulators, wheelchairs, and bone growth stimulators
- Integumentary supplies such as wound vacuum systems
- Home IV therapy supplies and medications

NOTE: This list is not all inclusive and is subject to change per policy updates.

Not covered:

- *Home Traction Units*
 - *DME replacements due to physical growth*
 - *DME to aid in the correction of congenital anomalies over the age of five (5) years*
 - *Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliances*
 - *Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage*
 - *Revision of durable medical equipment, except when made necessary by normal wear or use*
 - *Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness, lost, or stolen*
 - *Duplicate or similar items*
 - *Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates*
 - *Items which are primarily educational in nature or for vocation, comfort, convenience or recreation*
 - *Communication aids or devices to create, replace or augment communication abilities including, but not limited to, hearing aids, speech processors, receivers, communication boards, or computer or electronic assisted communication*
 - *Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools*
 - *Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas*
 - *Home Modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment*
 - *Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier*
 - *Remote control devices as optional accessories*
 - *Any other equipment and supplies which the Plan determines is not eligible for coverage*
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Home health services

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

The following is covered if approved by the Plan in lieu of Hospital or skilled nursing Facility:

- part-time or intermittent care by a RN or LPN/LVN
- part-time or intermittent home health aide services for direct patient care only
- physical, occupational, speech, inhalation, and intravenous therapies up to the maximum benefit allowable
- medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Member were Hospitalized
- limited to 40 visits in a calendar year and does not include meals, custodial care or housekeeping
- *one (1) home health visit constitutes four (4) hours of nursing care*
- Member must be home-bound to receive home health services

Not covered:

- *Nursing care requested by, or for the convenience of the patient or the patient's family (rest cures)*
- *Custodial or convalescent care*

Chiropractic

Non-Surgical Spinal treatment and chiropractic services

Limited to *twenty (20)* visits each Calendar Year, regardless of whether performed by a chiropractor or other licensed Provider authorized to perform such services

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

Smoking cessation treatment

Tobacco treatment covered up to \$100.00 and limited to once per lifetime for the therapy of the Member's choice from the following:

- physician counseling and treatment;
- smoking cessation classes; and
- visit to a Certified Respiratory Therapist.

Smoking deterrent medications will be covered per Plan policy with confirmation of smoking abstinence after a 6-month period.

Not covered: Hypnotism and Acupuncture

Reconstructive surgery

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

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

Coverage for mastectomy related benefits will be provided in a manner determined in consultation with the attending physician and Member. Coverage will be provided for reconstructive breast surgery and physical complications at all stages of a mastectomy, including lymphedema for those Members who had a mastectomy resultant from a disease, illness, or injury. For single mastectomy: coverage extends to the non-affected side to make it symmetrical with the affected breast post-surgical reconstruction. Breast prostheses and surgical bras and replacements are also covered (see Prosthetic devices in section 4(a)). Deductible and coinsurance applies as outlined in your *Summary of Payment*.

Not covered:

- *Surgeries related to sex transformation/sexual reassignment*
- *Cosmetic Services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services*

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- *Removal, revision or re-implantation of saline or silicone implants for: breast implant malposition; unsatisfactory aesthetic outcome; patient desire for change of implant; patient fear of possible negative health effects; or removal of ruptured saline implants that do not meet medical necessity criteria.*
 - *Surgeries to correct congenital deformities after the age of eight (8)*
 - *Prophylactic (preventive) mastectomy*

Oral and maxillofacial surgery

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

Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth, as long as the patient was covered under the Plan during the time of the injury or illness causing the damage

Care must be received within *six (6)* months of the injury/accident

Associated radiology services are included

“Injury” does not include injuries to Natural Teeth caused by biting or chewing

Coverage applies regardless of whether the services are provided in a Hospital or a dental office

NOTE: Anesthesia and Hospitalization charges for dental care are covered for a Member who:

- a. is a child under age five (5); or
 - b. is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician which places such a person at serious risk.
-

Not covered:

- *Removal of wisdom teeth*
 - *Natural teeth replacements including crowns, bridges, braces or implants*
 - *Diagnosis and treatment for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD)*
 - *Hospitalization for extraction of teeth*
 - *Dental x-rays or dental appliances*
 - *Shortening of the mandible or maxillae for cosmetic purposes*
 - *Services and supplies related to ridge augmentation, implantology, and Preventive vestibuloplasty*
 - *Dental appliances of any sort, including but not limited to bridges, braces, and retainers, appliances for treatment of TMJ/TMD*
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Transplants

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

Transplants that meet the United Network for Organ Sharing (UNOS) criteria and or plan policy requirements performed at Plan Participating Centers of Excellence and only for the following:

- a. Cornea
 - b. Heart
 - c. Heart/Lung
 - d. Kidney
 - e. Liver
 - f. Lung (single and bilateral)
 - g. Pancreas
 - h. Allogenic (donor) bone marrow transplants, and peripheral Stem Cell Support (myeloablative or non-myeloablative) for:
 - Acute or chronic myelogenous leukemia;
 - Burkitt's lymphoma;
 - Severe combined immunodeficiency disease;
 - Wiscott Aldrich syndrome;
 - Lysosomal storage disease;
 - Meyelodysplastic syndrome;
 - Aplastic anemia;
 - Non-Hodgkin's lymphoma;
 - Advanced Hodgkin's lymphoma;
 - Select cases of Sickle Cell anemia; or
 - Multiple myeloma.
 - i. Autologous (self) bone marrow transplants or peripheral Stem Cell Support associated with high dose chemotherapy for:
 - Acute leukemia;
 - Non-Hodgkin's lymphoma;
 - Hodgkin's disease;
 - Multiple myeloma;
 - Select cases of breast cancer;
 - Chronic myelogenous leukemia (CML);
 - Burkitt's lymphoma;
 - Germ cell tumors;
 - Primary amyloidosis;
 - Ewing's Sarcoma;
 - Primitive ectodermal tumors; or
 - Neuroblastomas
 - j. Prescribed post-transplant immunosuppressant outpatient drugs required as a result of a covered transplant
 - k. Coverage includes up to \$25,000 for acquisition fees
 - l. Medical expenses for the organ donor which are necessary for the transplant, and which are not covered by another group health plan or other coverage arrangement
-

Not covered:

- *Transplant evaluations with no end organ complications*
- *Harvesting and storage of stem cells*
- *Artificial organs, any transplant or transplant services not listed above*
- *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*
- *Costs related to locating and/or screening organ donors*
- *Services, chemotherapy, radiation therapy (or any therapy that damaged the bone marrow), supplies drugs and aftercare for or related to artificial or non-human organ transplants*
- *Services, chemotherapy, supplies, drugs and aftercare for or related to human organ transplants not specifically approved by the Plan's medical director or its designee*
- *Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating Center of Excellence*
- *Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria*

Anesthesia

We cover services of an anesthesiologist or other certified anesthesia Provider

SECTION 4(B) SERVICES PROVIDED BY A HOSPITAL OR OTHER FACILITY

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

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- This policy, including your application for coverage and any riders or amendments constitutes your entire contract of insurance.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- Participating Providers must provide or arrange your care and you must be Hospitalized in a Network Facility.
- Be sure to read Section 2, *How to get care*, for valuable information about conditions for coverage.
- **YOU MUST GET CERTIFICATION OF SOME OF THESE SERVICES.** See the benefits description below.

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Benefit Description

Inpatient Hospital

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

The following Hospital Services are covered:

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

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

Not covered:

- *Take-home drugs*
 - *Personal comfort items (telephone, television, guest meals and beds)*
 - *Private nursing care*
 - *Costs associated with private rooms*
 - *Admissions to Hospitals performed only for the convenience of the Member, the Member's family or the Member's Physician or other Practitioner and/or Provider*
 - *Custodial care*
 - *Convalescent care*
 - *Intermediate level or domiciliary care*
 - *Residential care*
 - *Rest cures*
 - *Services to assist in activities of daily living*
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Outpatient Hospital or Ambulatory Surgical Center

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

Health care services furnished in connection with a surgical procedure performed in a participating surgical center include:

- Outpatient Hospital surgical center
 - Outpatient hospital services such as diagnostic tests
 - Ambulatory surgical center (same day surgery)
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Not covered:

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

Skilled nursing care facility benefits

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

Skilled Nursing Facility Services are covered if approved by the Plan in lieu of continued or anticipated Hospitalization

The following Skilled Nursing Facility Services are covered when provided through a state licensed nursing Facility or program:

- a. Skilled nursing care, whether provided in an inpatient skilled nursing unit, a skilled nursing Facility, or a subacute (swing bed) facility
- b. Room and board in a skilled nursing Facility
- c. Special diets in a skilled nursing Facility, if specifically ordered

Skilled nursing Facility care is limited to *thirty (30)* days in a consecutive *twelve (12)* month period. Skilled nursing care in a Hospital shall be covered if the level of care needed by a Member has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the Hospital or in another Hospital or health care Facility within a *thirty-mile (30)* radius of the Hospital.

Not covered:

Custodial care

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

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

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

- a. The Member has been diagnosed with a terminal disease and a life expectancy of *six (6)* months or less;
- b. The Member has chosen a palliative treatment focus (i.e. emphasizing comfort and support services rather than treatment attempting to cure the disease or condition);
- c. The Member continues to meet the terminally ill prognosis as reviewed by the Plan's Medical Director over the course of care; and
- d. The hospice service has been approved by the Plan.

The following Hospice Services are Covered Services:

- a. Admission to a hospice Facility, Hospital, or skilled nursing Facility for room and board, supplies and services for pain management and other acute/chronic symptom management
- b. Part-time or intermittent nursing care by a RN, LPN/LVN, or home health aid for patient care up to *eight (8)* hours per day
- c. Social services under the direction of a Participating Provider
- d. Psychological and dietary counseling
- e. Physical or occupational therapy, as described under *Section 4(a)*
- f. Consultation and Case Management services by a Participating Provider
- g. Medical supplies, DME and drugs prescribed by a Participating Provider
- h. Expenses for Participating Providers for consultant or Case Management services, or for physical or occupational therapists, who are not group Members of the hospice, to the extent of coverage for these services as listed in this *Section 4(a)*, but only where the hospice retains responsibility for the care of the Member

Not covered: Independent nursing, homemaker services

SECTION 4(C) EMERGENCY SERVICES/ACCIDENTS

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

- This policy, including your application for coverage and any riders or amendments constitutes your entire contract of insurance.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 2, *How to get care*, for valuable information about conditions for coverage.

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What is an Emergency Medical Condition?

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

What is an urgent care situation?

An urgent care situation is a degree of illness or injury which is less severe than an Emergency Condition, but requires prompt medical attention within *twenty-four (24)* hours, such as stitches for a cut finger. If an urgent care situation occurs, Members should contact their Primary Care Physician immediately, if one has been selected, and follows his or her instructions. A Member may always go directly to a participating urgent care or after hour's clinic.

The Health Plan covers emergency services necessary to screen and stabilize Members without Certification in cases where a Prudent Layperson, acting reasonable, believed that an Emergency Medical Condition existed.

Benefit Description

Emergency within our Service Area

If an Emergency Condition arises, Members should proceed to the nearest emergency Facility that is a Participating Provider. If the Emergency Condition is such that a Member cannot go safely to the nearest participating emergency Facility, then the Member should seek care at the nearest emergency Facility.

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

With respect to care obtained from a Non-Participating Provider within the Plan's Service Area, the Plan shall cover emergency services necessary to screen and stabilize a Member and may not require Prospective (pre-service) Review of such services if a Prudent Layperson would have reasonably believed that use of a Participating Provider would result in a delay, or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

If a Member is admitted to a Non-Participating Provider, then the Plan will contact the admitting Physician to determine medical necessity and a plan for treatment. In some cases, where it is medically safe to do so, the Member may be transferred to a Participating Hospital.

Emergency outside our Service Area

If an Emergency occurs when traveling outside of the Plan's Service Area, Members should go to the nearest emergency Facility to receive care. The Member or a designated relative or friend must notify the Plan and the Member's Primary Care Physician, if one has been selected, as soon as reasonably possible, and no later than *forty-eight (48)* hours after physically or mentally able to do so.

Coverage will be provided for Emergency Conditions outside of the Service Area (at the In Network benefit level) unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

If an urgent care situation occurs when traveling outside of the Plan's Service Area, Members should contact their Primary Care Physician immediately, if one has been selected, and follows his or her instructions. If a Primary Care Physician has not been selected,

the Member should contact the Plan and follow the Plan's instructions. Coverage will be provided for urgent care situations outside the Service Area at the In Network level unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

Coverage outside of the United States

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

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

Not Covered: Emergency care provided outside the Service Area if the need for care could have been foreseen before leaving the Service Area

Ambulance and transportation services

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

- a. Medically Necessary; and
 - b. To the nearest Participating Provider equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by the Plan.
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Not covered:

- *Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other healthcare services*
 - *Transfers performed only for the convenience of the Member, the Member's family or the Member's Physician or other Practitioner and/or Provider*
 - *Non-emergency services and/or travel*
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SECTION 4(D) MENTAL HEALTH AND CHEMICAL DEPENDENCY BENEFITS

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

- This policy, including your application for coverage and any riders or amendments constitutes your entire contract of insurance.
- All benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 2, *How to get care*, for valuable information about conditions for coverage.
- **YOU MUST GET CERTIFICATION OF SOME OF THESE SERVICES.** See the benefits description below.

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Benefit Description

Mental health benefits (biologically-based)

Any mental illness which current medical research affirms is caused by a neurobiological disorder of the brain and which substantially impairs perception, cognitive function, judgment, and emotional stability and which limits the life activities of the person with the illness. This includes schizophrenia, schizo-affective disorder, bipolar affective disorder, major depression, obsessive-compulsive disorder, and other anxiety disorders which cause significant impairment of function; and other disorders proven to be biologically-based mental illnesses.

These are covered just like Health Care Services for any other condition. Biologically-based mental illnesses will be covered for treatment and diagnosis with the same dollar limits, Deductibles, Coinsurance factors, and restrictions as for other covered illnesses. Includes Partial Hospital Programs or Day Treatments.

Outpatient Professional services, including individual therapy by Providers such as psychiatrists, psychologists, or clinical social workers

Medication management

Diagnostic tests

Electroconvulsive therapy (ECT)

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

Inpatient services provided by a Hospital or other Facility and services in approved alternative care settings such as Partial Hospitalization

Not covered:

- *Non-biologically based mental illness services*
- *Long term care in a mental health facility*
- *Residential or convalescent care*
- *Counseling services including: marriage, family, or bereavement counseling, pastoral counseling, financial or legal counseling, and custodial care counseling*
- *Autistic disease of childhood*
- *Learning disabilities*
- *Behavioral problems*
- *Mental retardation or mental disorder services that, according to generally accepted professional standards, is not amenable to favorable modification (except for initial evaluation, diagnosis or crisis intervention)*
- *Services related to environmental change*
- *Behavioral therapy, modification, or training*
- *Milieu therapy*
- *Sensitivity training*
- *Eating Disorder*
- *Conduct Disorder*

Addiction and chemical dependency benefits

Chemical dependency services includes Alcohol, Chemical, and Gambling Treatment

Outpatient coverage is limited to *thirty (30)* days' care in any consecutive six-month period

Intensive Outpatient Programs (IOP) will apply towards Member's Deductible/Coinsurance benefit

Every *two (2)* days of Partial Hospital Program (PHP)/Day Treatment counts towards *one (1)* day of inpatient services and is applied toward the inpatient limit

NOTE: Certification is required for inpatient services; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 2.)

Inpatient coverage is limited to *thirty (30)* days in any consecutive six-month period with a *ninety (90)* day lifetime maximum for inpatient treatment at any Participating treatment Facility.

Not covered:

- *Non-biologically based mental illness services*
 - *Confinement 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)*
 - *Detoxification Services and other services related to Methadone or Cyclazocine therapy*
 - *Long term care in a mental health facility*
 - *Residential of convalescent care*
 - *Counseling services including: marriage, family, or bereavement counseling, pastoral counseling, financial or legal counseling, and custodial care counseling*
 - *Autistic disease*
 - *Learning disabilities*
 - *Behavioral problems*
 - *Mental retardation or mental disorder services that, according to generally accepted professional standards, is not amenable to favorable modification (except for initial evaluation, diagnosis or crisis intervention)*
 - *Services related to environmental change*
 - *Behavioral therapy, modification, or training*
 - *Milieu therapy*
 - *Sensitivity training*
 - *Conduct Disorder*
 - *Custodial Care*
 - *Intermediate level or domiciliary care*
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SECTION 4(E) PRESCRIPTION DRUG BENEFITS

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

- This policy, including your application for coverage and any riders or amendments constitutes your entire contract of insurance.
- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 2, *How to get care*, for valuable information about conditions for coverage.
- **YOU MUST GET CERTIFICATION OF SOME OF THESE SERVICES.** See the benefits description below.

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- **Where you can obtain them.** You must fill the prescription at a Network pharmacy. If you choose to go to a Non-Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy. Some injectable drugs are obtained through mail order. To enroll and obtain prior-approval to join the Injectable Drugs Program call 1-800-805-7938. Please refer to your *Summary of Pharmacy Benefits* handbook for a complete listing of injectable drugs that require Certification.
- **How you can obtain them.** You must present your ID card to your pharmacy, if you do not present your ID card to your pharmacy, you must pay 100% of the costs of the medication to the pharmacy.
- **We use a formulary.** 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 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.
- **Exception to formulary.** The Plan will use appropriate pharmacists and Practitioner and/or Providers 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.

NOTE: To request an exception to the formulary, please call the Utilization Management Department at 1-800-805-7938.

NOTE: Members must try formulary medications before an exception for the formulary will be made for non-formulary medication use.

- **There are dispensing limitations.** Prescriptions will be filled for up to a *thirty (30)* day supply per copay or coinsurance amount (or less, if prescribed) at one time (unless otherwise approved by the Plan). Those prescription drug classes identified as maintenance medications will be made available for up to a *ninety (90)* day supply. However, *three (3)* Copays or coinsurance amounts will apply. If you are going on vacation and need an extra supply of medication, you may request a “vacation override” to receive up to a *three (3) month’s* supply of medication. Please call the Plan for vacation override requests.

NOTE: If you request that you receive a brand-name drug when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic in addition to your Copay/Coinsurance. Additionally, if there is no generic equivalent, you will still be required to pay the brand name Copay.

Benefit Description

Covered medications and supplies

Drugs and medicines that by Federal law of the United States require a Physician's prescription for their purchase

- Self Administered Injectable drugs per Plan guidelines. Please refer to your *Summary of Pharmacy Benefits* for a list of medications (injectable and high cost medications) that must receive prior certification and must be obtained from Curascript by calling (888) 773-7376. If these medications are obtained from a retail pharmacy or physician office without prior certification by Sanford Health Plan Utilization Management Department the member will be responsible for the full cost of the medication.

Diabetic drugs (See section 4(a) for Diabetic supplies, equipment, and self-management training benefits)

Not Covered:

- *Drugs for treatment of sexual dysfunction, impotence, or erectile dysfunction (organic or non-organic in nature)*
 - *Drugs not listed in the Sanford Health Plan Formulary or without Certification or a formulary exception from The Plan*
 - *Replacement of a prescription drug due to loss, damage, or theft*
 - *Outpatient drugs dispensed in a Provider's office or non-retail pharmacy location*
 - *Drugs that may be received without charge under a federal, state, or local program*
 - *Drugs for cosmetic purposes, including baldness*
 - *Refills of any prescription older than one year*
 - *Compound medications with no legend medications*
 - *Acne medication for Members over age twenty-two(22)*
 - *B-12 injection (except for pernicious anemia)*
 - *Drug Efficacy Study Implementation ("DESI") drugs*
 - *Experimental or Investigational drugs or drug usage if not recognized by the Food and Drug Administration*
 - *Growth hormone, unless specifically covered elsewhere in this policy*
 - *Orthomolecular therapy, including nutrients, vitamins (including but not limited to prenatal vitamins), multi-vitamins with iron an/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances*
 - *Over-the-counter (OTC) Medications, equipment or supplies available (except for insulin, insulin syringes) 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)*
 - *Anorexia/Weight management drugs (except when Medically Necessary to treat morbid obesity)*
 - *Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia*
 - *Birth control devices including but not limited to, implantable contraceptive devices (such as IUDs or Implanon)*
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SECTION 4(F) DENTAL BENEFITS

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

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- This policy, including your application for coverage and any riders or amendments constitutes your entire contract of insurance.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- We cover Hospitalization for dental procedures only when a non-dental physical impairment exists which makes Hospitalization necessary to safeguard the health of the patient. See Section 4 (b) for inpatient Hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 2, *How to get care*, for valuable information about conditions for coverage.
- **YOU MUST GET CERTIFICATION OF THESE SERVICES.** See the benefits description below.

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Dental benefits

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

Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth, as long as the patient was covered under the Plan during the time of the injury or illness causing the damage

Care must be received within *six (6)* months of the occurrence

Associated radiology services are included

“Injury” does not include injuries to Natural Teeth caused by biting or chewing

Coverage applies regardless of whether the services are provided in a Hospital or a dental office

NOTE: Anesthesia and Hospitalization charges for dental care are covered for a Member who:

- a. is a child under age five (5); or
- b. is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician which places such a person at serious risk.

Not Covered:

- *Routine or preventive dental care*
 - *Natural teeth replacements including crowns, bridges, braces or implants*
 - *Diagnosis and treatment for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD)*
 - *Hospitalization for extraction of teeth*
 - *Removal of wisdom teeth*
 - *Dental x-rays or dental appliances*
 - *Shortening of the mandible or maxillae for cosmetic purposes*
 - *Services and supplies related to ridge augmentation, implantology, and Preventive vestibuloplasty.*
 - *Dental appliances of any sort, including but not limited to bridges, braces, and retainers, appliances for treatment of TMJ/TMD*
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SECTION 4(G) OUT-OF-NETWORK BENEFITS

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

- This policy, including your application for coverage and any riders or amendments constitutes your entire contract of insurance.
- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 2, *How to get care*, for valuable information about conditions for coverage.
- **NOTE:** The following services require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 2.)

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Out-of-Network Coverage means Covered Services that do not fit the definition of In Network Coverage set forth in Section 2 above. Specifically, Out-of-Network Coverage means Covered Services that are received:

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

You may choose to obtain benefits at our Out-of-Network benefits level by seeking care from Non-Participating Providers, except for the benefits listed below under "What is not covered." When you obtain covered non-emergency medical treatment from a Non-Participating Provider without authorization from us, you are subject to the Deductibles, Coinsurance and maximum benefit stated in your Summary of Payment and Summary of Pharmacy Benefits.

All Out-of-Network services are subject to Reasonable Cost. As indicated in the Summary of Payment, 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 Payment.

Members who live outside of the Plan's Service Area must use the Plan's Network Participating Providers as indicated on the Member Welcome Letter enclosed with the Member Identification Card. Members who live outside the Service Area will receive Identification Cards that display their network logo along with instructions on how to access this Network. If Member chooses to go to a Non-Participating Provider when access is available, claims will be paid at the Out-of-Network Benefit Level.

What is covered

Services listed in Section 4 above are covered with the following exceptions:

What is not covered Out of Network

- Services listed as "*Not covered*" in Section 4;
- Transplants and pre and post-transplant services at Non-Participating *Center of Excellence* Facilities; and
- Health Care Services ordered by a court or as a condition of parole or probation

SECTION 5. LIMITED AND NON-COVERED SERVICES

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

General Exclusions

1. Health Care Services provided either before the effective date of the Member's coverage with the Plan or after the Member's coverage is terminated
2. Health Care Services performed by any Provider who is a Member of the Member's immediate family, including any person normally residing in the Member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only Participating Provider in the area, the Member may go to a Non-Participating Provider and receive in Network coverage (Section 2). If the immediate family member is not the only Participating Provider in the area, the Member must go to another Participating Provider in order to receive coverage at the in Network level
3. 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
4. Health Care Services for injury or disease due to voluntary participation in a riot
5. Health Care Services for sickness or injury sustained in the commission of a felony
6. Health Care Services for sickness or injury sustained from declared or undeclared act of war or terrorism
7. Health Care Services that the Plan determines are not Medically Necessary
8. Experimental and Investigational Services
9. Services that are not Health Care Services
10. Treatment for intentionally self-inflicted injuries
11. Complications from a non-covered procedure or service
12. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner and/or Provider or electronic consultations
13. 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
14. Professional sign language and foreign language interpreter services
15. Charges for duplicating and obtaining medical records from *Non-Participating Providers* unless requested by the Plan
16. Charges for sales tax, mailing, interest and delivery
17. Charges for services determined to be duplicate services by the Plan medical director or designee
18. Charges that exceed the *Reasonable Costs* for Non-Participating Providers
19. Treatment of sexual dysfunction (organic or non-organic in nature), including prescription medications
20. Any service not specifically described as Covered Services in this *Policy*
21. Services to assist in activities of daily living
22. Alternative treatment therapies including, but not limited to: acupuncture, accupressure, aquatic whirlpool therapy, biofeedback, chelation therapy, massage therapy, fluidotherapy, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, sleep therapy (except for treatment of obstructive apnea), or therapeutic touch
23. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management

24. Mental retardation or mental disorder services that, according to generally accepted professional standards, is not amenable to favorable modification, except for initial evaluation, diagnosis or crisis intervention
25. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics
26. Any services or supplies for the treatment of obesity, including but not limited to: dietary regimen (except as related to covered nutritional counseling) and surgical treatment for reducing or controlling weight; bariatric treatment centers; medical care or prescription drugs; nutritional supplements (services supplies and/or nutritional sustenance products or food related to enteral feeding except when it's the sole means of nutrition); food supplements; services of inpatient and/or outpatient treatment of bulimia, anorexia or other eating disorders which consist primarily of behavior modification, diet and weight monitoring and education; any services or supplies that involve weight reduction as the main method of treatment, including medical or psychiatric care our counseling; weight loss or exercise programs; nutritional supplements; appetite suppressants and supplies of a similar nature; and products including but not limited to liposuction, gastric balloons, jejunal bypasses and wiring of the jaw
27. Developmental Delay Care including services or supplies, regardless of where or by whom they are provided which:
 - Are less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test; or
 - Are not rehabilitative in nature (restoring fully developed skills that were lost or impaired due to injury or illness);
 - Are educational in nature; vocational and job rehabilitation, recreational therapy; or
 - Are 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.

Neither physical nor occupational therapy is covered for developmental delay. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability, is not covered.
28. Sexual re-assignment
29. Panniculectomy or sequela (i.e. anemia, breast reduction, hernia repair, gallbladder removal) as result of gastric bypass surgery
30. Cosmetic Services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services
31. Removal of skin tags
32. Food items for medical nutrition therapy
33. Any fraudulently billed charges or services received under fraudulent circumstances
34. Any services, supplies or prescriptions drugs that are specifically excluded by a medical rider amending this Policy
35. Maternity care (Except for Elite1 \$2,000 Plan as described in the *Summary of Payment*) including:
 - inpatient maternity care, delivery charges, and any related services;
 - prenatal and postnatal care and any related services;
 - newborn care for the first *forty-eight (48)* hours for vaginal delivery and *ninety-six (96)* hours for cesarean birth;
 - family planning services including consultations and pre-pregnancy planning; and
 - infertility services including testing for the diagnosis of infertility.

Pre-Existing Conditions

1. Health Care Services for Pre-Existing Conditions are excluded for a period of *twelve (12)* months following the effective date of coverage. The *twelve (12)* month period shall be reduced by the aggregate number of days that a Member was covered under Creditable Coverage.
2. This Pre-Existing Condition exclusion does not apply to newborn children or children placed for adoption, or adopted children under eighteen (18) provided that coverage is applied for the child and the required Premium payments are made within *thirty-one (31)* days from the date of birth, adoption or placement for adoption.
3. The Plan will not count days of Creditable Coverage that occur before a significant break in coverage. A significant break in coverage is a period of *sixty-three (63)* consecutive days during all of which a Member does not have any Creditable Coverage, excluding any waiting periods and affiliation periods. Periods of Creditable Coverage shall be counted without regard to the specific benefits covered during the period.
4. Members shall have the right to provide the Plan with evidence of prior Creditable Coverage, including the right to secure a Certificate of Creditable Coverage from a prior health benefit plan or an insurer and have the Plan assist in obtaining such a certificate.
5. Prior to imposing a Pre-Existing Condition exclusion, the Plan shall inform the Member in writing of its determination of any Pre-Existing Condition exclusion period that applies and the basis for the determination; provide an opportunity for the Member to submit additional materials regarding prior Creditable Coverage; provide an explanation of any appeals procedures; and provide a reasonable opportunity to submit additional evidence of Creditable Coverage.

Pre-Existing Condition Waiting Period

A preexisting condition waiting period is a specified amount of time, beginning on your effective date, which you may have to wait before benefits for Pre-Existing conditions are available under this Policy.

A Preexisting Condition waiting period of *twelve (12)* consecutive months applies if the Member requiring services or supplies has a Pre-Existing Conditions and any of the following statements are true:

- Neither you nor any other covered Members had Creditable Coverage within *sixty-three (63)* consecutive days of your application;
- The covered Member's Creditable Coverage was not in effect for a sufficient amount of time to satisfy the *twelve (12)* month waiting period for Pre-Existing Conditions under this coverage. In this case, the *twelve (12)* month waiting period for Pre-Existing Conditions, applicable to each family member under this coverage will be credited for the amount of time each family member was covered under Creditable Coverage.

Special situations affecting coverage

- a. Neither the Plan, nor any Participating Provider, shall have any liability or obligation because of a delay or failure to provide services as a result of the following circumstances: Complete or partial destruction of the Plan's facilities;
- b. Declared or undeclared acts of War or Terrorism;
- c. Riot;
- d. Civil insurrection;
- e. Major disaster;
- f. Disability of a significant portion of the Participating Providers;
- g. Epidemic; or
- h. A labor dispute not involving the Plan Participating Providers, the Plan will use its best efforts to arrange for the provision of Covered Services within the limitations of available facilities and personnel. If provision or approval of Covered Services under this Contract is delayed due to a labor dispute involving the Plan or Participating Providers, Non-Emergency Care may be deferred until after resolution of the labor dispute.

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

Services covered by other payors

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

The Plan is not issued in lieu of nor does it affect any requirements for coverage by Worker's Compensation. This Plan contains a limitation which states that health services for injuries or sickness which are job, employment or work related for which benefits are provided or payable under any Workers' Compensation or Occupational Disease Act or Law, are excluded from coverage by the Plan. However, if benefits are paid by the Plan and it is determined that Member is eligible to receive Workers' Compensation for the same incident; the Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Member will consent to reimburse the Plan the full amount of the Reasonable Costs when entering into any settlement and compromise agreement, or at any Workers' Compensation Division Hearing. The Plan reserves its right to recover against Member even though:

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

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

2. Health Care Services received directly from Providers employed by or directly under contract with the Member's employer, mutual benefit association, labor union, trust, or any similar person or group.
3. Health Care Services for injury or sickness for which there is other non-group insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess, or contingent to the Plan. If the benefits subject to this provision are paid, the Plan may exercise its Rights of Subrogation.
4. Health Care Services for conditions that under the laws of This State must be provided in a governmental institution.
5. Health Care Services covered by any governmental health benefit program such as Medicare, Medicaid, ESRD and Tri-Care, unless applicable law requires the Plan to provide primary coverage for the same.

Services and payments that are the responsibility of Member

1. Out-of-pocket costs, including Copays, Deductibles, and Coinsurance are the responsibility of the Member in accordance with the attached Summary of Payment. and Summary of Pharmacy Benefits. Additionally, the Member is responsible to a Provider for payment for Non-Covered Services;
 2. Finance charges, late fees, charges for missed appointments and other administrative charges; and
 3. Services for which a Member is not legally, or as customary practice, required to pay in the absence of a group health plan or other coverage arrangement.
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SECTION 6. HOW SERVICES ARE PAID FOR BY THE PLAN

Reimbursement of Charges by Participating Providers

When you see Participating Providers, receive services at Participating Providers and facilities, or obtain your prescription drugs at Network pharmacies, you will not have to file claims. You will need to present your identification card and pay your Copay/Coinsurance.

When a Member receives Covered Services from a Participating Provider, the Plan will pay the Participating Provider directly, and the Member will not have to submit claims for payment. The Member's only payment responsibility, in this case, is to pay the Participating Provider, at the time of service, any Copay, Deductible, or Coinsurance amount which is required for that service.

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

In any event, the claim must be submitted to the Plan no later than *one hundred twenty (120)* days after the date that the cost was incurred, unless the claimant was legally incapacitated.

Reimbursement of Charges by Non-Participating Providers

You will only need to file a claim when you receive emergency services from Non-Participating Practitioner and/or Providers. Sometimes these Practitioner and/or Providers submit a claim to us directly. Check with the Practitioner and/or Provider. If you need to file the claim, here is the process:

The Member must give the Plan written notice of the costs to be reimbursed.

Claim forms are available from the Plan's Member Services Department to aid in this process. Bills and receipts should be itemized and show:

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

Time Limits. Claims must be submitted to the Plan within *one hundred eighty (180)* days after the date that the cost was incurred.

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

Time Frame for Payment of Claims

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

When a Member receives Covered Services from a Non-Participating Provider and payment is to be made according to Plan guidelines, the Plan will arrange for direct payment to either the Non-Participating Provider or the Member, per plan policy. If the Provider refuses direct payment, the Member will be reimbursed for the Reasonable Costs of the services in accordance with the terms of This Contract. The Member will be responsible for any expenses that exceed Reasonable Costs, as well as any Copay, Deductible, or Coinsurance which is required for the Covered Service.

When we need additional information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.

SECTION 7. PROBLEM RESOLUTION

MEMBER GRIEVANCE 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 request a review of any adverse decision determination by Sanford Health Plan. The following types of Adverse Determinations will be considered for the appeals process.

Definitions

Adverse determination: Means any of the following:

- a) A determination by the Plan that, based upon the information provided, a request by a Member for a benefit upon application of any Utilization Review technique does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness or is determined to be Experimental or Investigational and the requested benefit is therefore denied, reduced, or terminated or payment is not provided or made, in whole or in part, for the benefit;
- b) The denial, reduction, termination, or failure to provide or make payment in whole or in part, for a benefit based on a determination by the Plan of a Member's eligibility to participate in the benefit plan; or
- c) Any Prospective (pre-service) Review or retrospective (post-service) review determination that denies, reduces, terminates, or fails to provide or make payment, in whole or in part, for a benefit.

Grievance: A written complaint, or oral complaint (if the complaint involves an Urgent Care Request), submitted by or on behalf of a Member regarding:

- a) Availability, delivery, or quality of Health Care Services;
- b) Claims payment, handling, or reimbursement for Health Care Services; or
- c) Any other matter pertaining to the contractual relationship between a Member and the health carrier. A request for an expedited review need not be in writing.
- d) An appeal (by NCQA definition) is a request to change a previous decision made by the Plan.

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

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 a prudent layperson's judgement; or
 - (2) In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
- In determining whether a request is "urgent," the Plan shall apply the judgment of a Prudent Layperson as defined in Section 10. 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.

Types of Adverse determinations

Types of Adverse determinations include but are not limited to:

1. **Benefits Denial** – a denial that is specifically **excluded** from the Member's benefits package or is not considered a Medical Necessity Denial.
2. **Medical Necessity Denial** – a denial of care of services that could be considered a Covered Service depending on the circumstances. Examples:
 - a. Experimental Treatments
 - b. Cosmetic procedures
 - c. Pharmaceutical authorizations (Certifications)
 - d. Access to Out-of-Network Providers
 - e. Continued care or services

Types of Grievances (Appeals)

There are two types of Grievances:

1. Those involving Adverse Determinations and
2. Those not involving Adverse Determinations (i.e. Claims Denials – denials based on timely and accurate filing of claims or failure to request authorization (Certification) of services.)

These grievances can be of the following types:

1st Level Grievances for Prospective (pre-service) or Retrospective (post-service) Reviews: A request to change a previous Adverse Determination made by Sanford Health Plan.

- A **prospective (pre-service) grievance** is a request to change an Adverse Determination that the Plan must approve in whole or in part in advance of the Member obtaining care or services.
- A **retrospective (post-service) grievance** is a request to change an Adverse Determination for care or services already received by the Member.

Expedited Grievance for Urgent Care Reviews: A request to change a previous Adverse Determination made by Sanford Health Plan for an Urgent Care Request.

Additional Voluntary (2nd Level) Reviews: A request to change an Adverse Determination made at the 1st Level Grievance Review Process.

External Review: An external review is a request for an independent, external review of a *medical necessity* final determination made by Sanford Health Plan through its external appeals process.

Audit Trails

Audit trails for Adverse Determinations and Grievances are provided by the Plan's Information System and an Access database which includes documentation of the Adverse Determination and/or Grievance by date, service, procedure, and reason. The Grievance file includes telephone notification, and documentation indicating the date; the name of the person spoken to; the Member; the service, procedure, or admission certified; and the date of the service, procedure, or Adverse Determination and reason for determination. If the Plan indicates authorization (Certification) by use of a number, the number must be called the "Authorization number."

Filing Deadline

Grievances can be made for up to *one hundred eighty (180) days from notification of the Adverse Determination.*

Within *one hundred eighty (180)* days after the date of receipt of a notice of an Adverse Determination sent to a Member or the Member's Authorized Representative, the Member or their Authorized Representative may file a Grievance with the Plan requesting a **first level review** of the Adverse Determination.

The Member or the Authorized Representative should contact the Plan by calling or sending a written Grievance to the following address: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. Phone: (800) 752-5863 or (605) 328-6800.

1st Level Standard Review Procedure for Complaints (Grievances NOT involving Adverse Determination)

A standard appeal may be requested by a Member, his or her representative or Practitioner and/or Provider by writing or telephoning the Member Services Department at 1-800-752-5863 or (605) 328-6800. The Grievance process is included in the Member's initial determination letter.

Upon receipt of the Grievance, the Plan shall designate a person or persons to conduct the standard review. The Plan shall provide the Member or their Authorized Representative with the name, address and telephone number of a person designated to coordinate the standard review on behalf of the Plan.

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.

The attending Practitioner and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Grievance within *three (3)* working days of receipt of the Grievance.

The Plan will notify the Member or their Authorized Representative of the determination in writing or electronically within *twenty (20)* working days of receipt of Grievance.

Lack of Necessary Information

If the Health Plan is unable to make a decision due to lack of necessary information or for reasons beyond its control, it will notify the Member or the Member's Authorized Representative of what specific information is necessary to make the decision on or before the *twentieth (20)* working days after receipt of the request. In lieu of notifying the Member, the Plan can notify the Practitioner of the information needed if the request for healthcare services came from the Practitioner. The decision time frame will be extended once, for up to *ten (10)* working days after the date of notifying the Member or the Member's Authorized Representative of the failure to submit sufficient information as requested.

If the Member or a Member's Authorized Representative files a Grievance for an Adverse Determination, a thorough investigation of the substance of the Grievance will be conducted by an individual designated by the Plan. A person who was not involved in the initial determination nor the subordinate of any person involved in the initial determination will review the Grievance.

The Plan will document the substance of the Grievance and any actions taken. Full investigation of the substance of the Grievance, will be coordinated by the Grievance Coordinator.

If the 1st Level Standard Review determination is adverse, the Member shall be informed of the following additional rights:

- (a) To request an Additional Voluntary (2nd level) review after receipt of this notice at which the Member or an Authorized Representative will be notified within *five (5)* working days of their rights and responsibilities to participate in the review panel; or

- (b) To contact the SD Division of Insurance at:

SD Dept. of Revenue & Regulation
Division of Insurance
445 East Capitol Avenue
Pierre, SD 57501-3185 Fax: (605) 773-5369 Phone: (605) 773-3563

- (c) Or, upon completion of the Plan's Grievance Procedures, to file a civil suit in a court of competent jurisdiction.

Grievance Procedure involving Adverse Determinations

If the Member or a Member's authorized representative files a Grievance for an Adverse Determination, 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.

The attending Practitioner and/or Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Grievance within *three (3)* working days of receipt of the Grievance.

Full and thorough investigation of the substance of the Grievance, including any aspects of clinical care involved will be coordinated by the Grievance 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 Grievance. 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, however, the Practitioner who made the initial Adverse Determination may review the appeal and overturn the previous decision. The Plan will document the substance of the Grievance and any actions taken.

Upon receipt of a Grievance or other problem regarding an Adverse Determination for a prospective (pre-service) or retrospective (post-service) review, the Plan will make a decision and notify the Member in writing of its proposed resolution.

For Retrospective (post-service) Review Grievances: the Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the appeal in writing or electronically within *sixty (60)* calendar days of receipt of Grievance. Member notification of the Grievance response will be logged for reference.

For Prospective (pre-service) Review Grievances: the Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the appeal in writing or electronically within *thirty (30)* calendar days of receipt of Grievance.

If the 1st Level Grievance Review determination is adverse, the Member shall be informed of the following additional rights:

- a. To request an Additional Voluntary (2nd level) review. Within *five (5)* working days after receipt of the request for a 2nd level review, the Plan will send notice to the Member or an Authorized Representative their rights and responsibilities to participate in the review panel; or
- b. To contact the SD Division of Insurance at:

SD Dept. of Revenue & Regulation
Division of Insurance
445 East Capitol Avenue
Pierre, SD 57501-3185
Fax: (605) 773-5369
Phone: (605) 773-3563
- c. Upon completion of the Plan's Grievance Procedures, to file a civil suit in a court of competent jurisdiction; or
- d. To initiate the external review process for Adverse Determinations based on medical necessity. Refer to the "INDEPENDENT, EXTERNAL REVIEW OF FINAL DETERMINATIONS" Section below for details on this process.

Expedited Grievance Procedure

An expedited Grievance procedure is used when the condition is an emergency or urgent in nature, as defined by this Policy in Section 10.

An expedited review involving Urgent Care Requests for Adverse Determinations of **prospective (pre-service) or Concurrent Reviews** must be utilized if the Member or Practitioner and/or Provider acting on behalf of the Member believes that an expedited determination is warranted. 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 and/or Provider of care. A designated Physician advisor not involved in the initial Adverse Determination will conduct the review and will be available to discuss the case with the attending Practitioner and/or Provider on request. 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 request; however, the Practitioner who made the initial Adverse Determination may review the appeal and overturn the previous decision.

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

If the expedited review process does not resolve a difference of opinion, the Member or representative may request an Additional Voluntary (2nd level) review. Sanford Health Plan will review this request as a retrospective Grievance.

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

Additional Voluntary (2nd Level) Review

If a Member requests an additional voluntary (2nd level) review, the Plan will notify the Member in writing of their right to:

- (a) Request the opportunity to appear in person before the review panel of the Plan's designated representatives within *five (5)* working days after the date of receipt of the notice;
- (b) Receive, upon request, copies of documents and records that is not confidential or privileged relevant to the request for benefits;
- (c) Present the Member's case to the review panel;
- (d) Submit written comments, documents, records relevant to the request for benefits to the panel for consideration when conducting the review both before and, if applicable, at the review meeting;
- (e) Ask questions of the review panel; and
- (f) Be assisted or represented by an individual of the Member's choice.

Note: A Member's right to a fair review is not conditional on the Member's appearance at the review.

The review panel shall schedule and hold a review meeting within *forty five (45)* working days after the date of receipt of the request. The Member or, if applicable, the Member's authorized representative shall be notified in writing at least *fifteen (15)* working days in advance of the date of the review meeting. The review meeting shall be held during regular office hours at a location reasonably accessible to the Member or in any case in which a face-to-face meeting is not practical for geographic reasons, a review panel can be held via conference call, video conferencing, or other appropriate technology at the Plan's expense. If the Plan chooses to have an attorney present, the Member shall be notified at least *fifteen (15)* days prior to the meeting and that the Member may wish to obtain legal representation also. The Plan will not unreasonably deny a request for postponement of the review made by the Member or the Member's authorized representative. If the Member does not request to appeal before the panel, the review panel will issue a decision and notify the Member in writing of the decision within *forty five (45)* working days after the earlier of:

- (a) the date of the request not to appear before the panel, or
- (b) the date that the Member's opportunity to request to appear before the review panel expires.

In conducting the review, the review panel shall take into consideration all comments, documents, records and other information regarding the request for benefits submitted by the Member or Member's authorized representative without regard to whether the information was submitted or considered in the 1st level review. If a reviewing health care professional with the expertise is not reasonably available and there has been a denial of a health care service, the reviewing health care professional is only ineligible to review decisions if the professional meets both of the following criteria:

- (1) The professional is a provider in the covered person's health benefit plan; and
- (2) The professional has financial interest in the outcome of the review.

The majority of members on the review panel shall be comprised of individuals who were not involved in the first level review decision and be health care professionals who have appropriate expertise. A person involved in the 1st level review may be involved in the review panel if a majority of the rest of the panel members were not involved in the 1st level review. The review panel shall issue a written decision within *five (5)* working days of completing the review meeting. The written decision shall include:

- The titles and qualifying credentials of the panel;
- A statement of the panel's understanding of the nature of the appeal;
- The rationale for the panel's decision;
- Reference to evidence or documentation considered by the panel;
- If applicable, instructions for requesting a written statement on the clinical rationale; and
- Notice of the Member's right to contact the Division of Insurance for assistance including phone number and address.

The decision of the Plan's panel is legally binding on the Health Plan.

Written Notification Process for Grievances

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

1. The specific reason for the decision in easily understandable language;
2. The titles and qualifications, including specialty, of the person or persons participating in the first level review process (Reviewer names are available upon request);
3. Reference to the evidence, benefit provision, guideline, and /or protocol used as the basis for the decision and notification that the Member on request can have a copy of the actual benefit provisions, guidelines, and protocols free of charge;
4. Notification the Member can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Member's benefit request;
5. Statement of the reviewer's understanding of the Member's Grievance;
6. The Reviewer's decision in clear terms and The Contract basis or medical rationale in sufficient detail for the Member to respond further;
7. Notification and instructions on how the Practitioner and/or Provider can contact the Physician or appropriate behavioral health (for behavioral health reviews) to discuss the determination;
8. If the Adverse Determination is based on a medical necessity or Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of The Plan to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
9. If applicable, instructions for requesting:
 - (i) A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Determination, as provided in subsection (d) of this section; or
 - (ii) The written statement of the scientific or clinical rationale for the determination, as provided in subsection (e) of this section;
10. For Adverse Determinations of **prospective (pre-service) or retrospective (post-service) review** a statement indicating:
 - a) A description of the process to obtain an additional voluntary (2nd level) review of the first level review decision involving an Adverse Determination;
 - b) The written procedures governing the voluntary review, including any required time frame for the review; and
 - c) The Member's right to bring a civil action in a court of competent jurisdiction;
11. If a determination is adverse, the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your state insurance director." and the right to bring a civil action in a court of competent jurisdiction;
12. Notice of the Member's right to contact the Division of Insurance for assistance at any time at:

SD Dept. of Revenue & Regulation
Division of Insurance
445 East Capitol Avenue
Pierre, SD 57501-3185 Fax: (605) 773-5369 Phone: (605) 773-3563
13. Notice of the right to initiate the External Review process for Adverse Determinations based on medical necessity. Refer to "Independent, External Review Of Final Determinations" in this Section for details on this process. Final denial letters will contain information on the circumstances under which appeals are eligible for external review and information on how the Member can seek further information about these rights.
14. If the Adverse Determination is completely overturned, the decision notice must state the decision and the date.

Independent, External Review of Final Determinations

South Dakota Independent, External Review Requirements are only available to *medical necessity* adverse determinations.

In the state of South Dakota, where state laws relating to independent, external appeals do not exist, the Plan will follow the procedure for providing independent, external review of final determinations as outlined by the National Committee on Quality Assurance (NCQA).

With the Member's permission, the Plan may refer an appeal directly to an independent review organization without conducting an internal review.

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

1. Members the right to an independent, third party, binding review whenever they meet the following eligibility criteria:
 - a. the Member is appealing an Adverse Determination that is based on medical necessity (benefits Adverse Determinations are not eligible);
 - b. the Member has not appealed to the State of South Dakota;
 - c. Sanford Health Plan has completed one level of internal appeal review and its decision is unfavorable to the Member, or has exceeded the time limit for making a decision, or Sanford Health Plan has elected to bypass the level of appeal with the Member's permission, without good cause and without reaching a decision;
 - d. the total costs related to the entire episode of care or course of treatment prescribed by a Practitioner and/or Provider has exceeded \$500; and
 - e. the request for independent, external review is filed within *one hundred eighty (180)* calendar days of the date that the Plan's Adverse Determination was made.
2. Notification to Members about the independent, external appeal program and decision are as follows:
 - a. General communications to Members, at least annually, to announce the availability of the right to independent, external review.
 - b. Letters informing Members and Practitioners and/or Providers of the upholding of an Adverse Determination covered by this standard including notice of the independent, external appeal rights, directions on how to use the process, contact information for the independent, external review organization, and a statement that the Member does not bear any costs of the independent, external review organization.
 - c. The external review organization will communicate its decision in clear terms in writing to the Member and the Plan. The decision will include the medical necessity rationale and the time frame for implementation, list of titles and qualifications, including specialty, of individuals participating in the appeal review, statement of the reviewer's understanding of the pertinent facts of the appeal and reference to evidence or documentation used as a basis for the decision and, in cases of an Adverse Determination, instructions for requesting a written statement of the clinical rationale, including the clinical review criteria used.
 - d. The external review organization must also notify the Member how and when Members receive any payment or service in the case of overturned Adverse Determinations.
3. Conduct of the appeal program as follows:
 - a. Sanford Health Plan contracts with the independent, external review organization that:
 - i. conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the internal appeal.
 - ii. completes their review and issues a final decision for non-urgent appeals within *thirty (30)* calendar days of the request. For clinically urgent appeals the review and decision will take *three (3)* calendar days, with the possibility of extending to *five (5)* days for good cause. The organization or the treating Physician may identify a clinically urgent appeal.
 - iii. has no material professional, familial or financial conflict of interest with Sanford Health Plan.
 - b. With the exception of exercising its rights as party to the appeal, Sanford Health Plan must not attempt to interfere with the independent, external review organization's proceeding or appeal decision.
 - c. Sanford Health Plan will provide the independent external review organization with all relevant medical records as allowed by state law, supporting documentation used to render the decision pertaining to the Member's case (summary description of applicable issues including the Plan's decision, criteria used and clinical reasons, UM criteria, communication from the Member to the Plan regarding the appeal), and any new information related to the case that has become available since the internal appeal decision.
 - d. The Member is not required to bear costs of the independent, external review organization, including any filing fees.

However, the Plan is not responsible for costs associated with a hired attorney or traveling to an independent, external review hearing.

- e. The Member or his/her legal guardian may designate in writing a representative to act on his /her behalf. A Practitioner and/or Provider may not file an appeal without explicit, written designation by the Member.
 - f. The independent, external review organization's decision is final and binding to the Plan and the Plan implements the independent, external review organization's decision within the time frame specified by the independent, external review organization. The decision is not binding to the Member, because the Member's have legal rights to further pursue appeals in court if they are dissatisfied with the outcome.
4. Sanford Health Plan obtains from the independent, external review organization, or maintains and tracks, data on each appeal case, including descriptions of the denied item(s), reasons for denial, independent, external review organization decisions and reasons for decisions. Sanford Health Plan uses this information in tracking and evaluating its medical necessity decision-making process and improving the quality of its clinical decision making procedures. This information is reported to the Medical Management Quality Committee when a case is resolved for discussion and plan of care or action.

SECTION 8. COORDINATION OF BENEFITS

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

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

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

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

Applicability

This Coordination of Benefits (COB) provision applies to this Plan when a Member or the Member's covered Dependent has health care coverage under more than one Plan. "Plan" and "this Plan" are defined below.

The order of benefit determination rules govern the order in which each plan will pay a claim for benefits. The plan that pays first is called the primary plan. The primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another plan may cover some expense. The plan that pays after the primary plan is the secondary plan. The secondary plan may reduce the benefits it pays so that payments from all plans does not exceed 100% of the total allowable expense.

Definitions (for COB Purposes Only)

1. **"Plan"** is any of the following which provides benefits or services for, or because of, medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts. Plan includes:
 - a. Group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile; and Medicare or any other federal governmental plan as permitted by law.
 - b. "Plan" does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage (as defined by state law); school accident type coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under a governmental plan, unless permitted by law.
2. **"This Plan"** refers to this certificate and means, in a COB provision, the part of the contract providing health care benefits to which the COB provision applies and which may be reduced because of the benefits of another plan. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.
3. **"Primary Plan/Secondary Plan"**: The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan when the person has health care coverage under more than one plan.

When this Plan is a Primary Plan, its benefits are determined before those of the other plan and without considering the other plan's benefits.

When this Plan is a Secondary Plan, its benefits are determined after those of the other plan and benefits may be reduced because of the other plan's benefits so that all plan benefits do not exceed 100% of the total Allowable Expense..

When there are more than *two* (2) plans covering the Member, this Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.
4. **"Allowable Expense"** means a necessary, reasonable and customary health care service or expense including Deductibles, Coinsurance, or Copays, that is covered in full or in part by one or more plans covering the person for whom the claim is made. If a plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. In addition, any expense that a provider by law in or accordance with a contractual agreement is prohibited from charging a covered person is not an allowable expense. Expenses that are not allowable include the following:

- a. The difference between the cost of a private Hospital room and the cost of a semi-private Hospital room (unless the patient's stay in a private Hospital room is Medically Necessary either in terms of generally accepted medical practice, or as specifically defined by the Plan) is not an allowable expense;
 - b. If a person is covered by two or more plans (excluding Medicare, see "*Coordination of Benefits with Medicare*" Section below) that compute the benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specified benefit is not an allowable expense;
 - c. If a person is covered by two or more plans (excluding Medicare, see "*Coordination of Benefits with Medicare*" Section below) that provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense;
 - d. If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the secondary plan to determine its benefits.
 - e. When benefits are reduced under a Primary Plan because a Member does not comply with The Plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, Certification of admissions or because the person has a lower benefit because the person did not use a preferred Practitioner and/or Provider.
5. "**Claim**" means a request that benefits of a plan be provided or paid in the form of services (including supplies), payment for all or portion of the expenses incurred, or an indemnification.
 6. "**Claim Determination Period**" means a Calendar Year over which allowable expenses are compared with total benefits payable in the absence of COB to determine if overinsurance exists. However, it does not include any part of a year during which a person has no coverage under this Plan, or any part of a year before the date this COB provision or similar provision takes effect.
 7. "**Closed Panel Plan**" is a plan that provides health benefits to Members primarily in the form of services through a panel of Practitioner and/or Providers that have contracted with or are employed by The Plan, and that limits or excludes benefits for services provided by other Practitioner and/or Providers, except in cases of emergency or Plan authorized referral by a Participating Provider.
 8. "**Custodial Parent**" means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

Order of Benefit Determination Rules

1. **General.** When two or more plans pay benefits, the rules for determining the order of payment is as follows:
 - a. The primary plan pays or provides benefits as if the secondary plan or plans did not exist.
 - b. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.
 - c. If multiple contracts providing coordinated coverage are treated as a single plan, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with order of benefit determination rules.
 - d. If a person is covered by more than one *secondary* plan, the order of benefit determination rules decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of any primary plan and the benefits of any other plan which has its benefits determined before those of that secondary plan.
 - e. A plan that does not contain a COB provision that is consistent with this regulation is always primary unless the provisions of both plans, regardless of the provisions of this section, state that the complying plan is primary. The exception is coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of The Plan provided by the contact holder. For example, major medical coverage that is superimposed over base plan Hospital and surgical benefits, and insurance type coverage that is written in connection with a closed panel plan to provide Out-of-Network benefits.

- f. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.
2. **Rules.** This Plan determines its order of benefits using the first of the following rules which applies:
- a. Non-Dependent/Dependent.** The plan which covers the person as a group Member, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent. However, if the person is also a Medicare beneficiary, Medicare is:
- i. secondary to the Plan covering the person as a Dependent; and
 - ii. primary to the Plan covering the person as other than a Dependent, for example a retired group Member; then the order of benefits between the two plans is reversed so that the plan covering the person as a group Member, Member, or Subscriber is secondary and the other plan is primary.
- b. Child Covered Under More Than One Plan.** Unless there is a court decree stating otherwise, the order of benefits when a child is covered by more than one plan is determined as follows:
- i. For a dependent child whose parents are married or are living together, whether or not they have ever been married:
 - The primary plan is the plan of the parent whose birthday is earlier in the year; or
 - If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - ii. For a dependent child whose parents are divorced or separated or not living together (whether or not they ever have been married), the order of benefits is:
 - If a court decree states that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods or plan years commencing after The Plan is given notice of the court decree.
 - If a court states the both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of paragraph "i" above shall determine the order of benefits.
 - If a court decree states that parents have joint custody without specifying that one parent has responsibility for the healthcare expenses of health care coverage of the dependent child, the provisions of paragraph "i" above shall determine the order of benefits; or
 - If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
 - The plan of the custodial parent;
 - The plan of the Spouse of the custodial parent;
 - The plan of the noncustodial parent; and then
 - The plan of the Spouse of the noncustodial parent.
- c. Active employee or retired or laid-off Group Member.** The benefit of a plan which covers a person as an active employee, that is, an employee who is neither laid off nor retired (or as that group Member's Dependent) is primary. The plan covering that same person as a retired or laid-off employee is the secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other plan does not have this rule, and as a result, The Plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a Dependent of an actively working Spouse will be determined under Rule 2(a) above.
- d. COBRA or State Continuation Coverage.** If a person whose coverage is provided pursuant to COBRA or under a right of continuation pursuant to a federal or state law also is covered under another plan, the plan covering the person as an employee, member, subscriber or retiree or covering the person as a dependent of an employee, member subscriber or retiree is the primary plan and the COBRA or state or other federal continuation coverage is the secondary plan. If the other plan does not have this rule, and as a result, The Plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a Dependent of an actively working Spouse will be determined under Rule 2(a) above.
- e. Longer or Shorter Length of Coverage.** The plan that covered the person as an employee, member policyholder, subscriber, or retiree longer is the primary plan and the plan that covered the person the shorter period of time is the secondary plan.
- f. Coordinating Benefits with non-complying plans.** A plan that complies with the order of benefit determination rules of this section may coordinate its benefits with a plan that is excess or always secondary or that uses order of benefit determination rules that are inconsistent with those contained in this section on the following basis:
- i. If the complying plan is the primary plan, it shall pay or provide its benefits first;
 - ii. If the complying plan is the secondary plan, it shall pay or provide its benefits first, but the amount of the benefits payable shall be determined as if the complying plan were the secondary plan. In such a situation, the payment shall be the limit of the complying plan's liability; and
 - iii. If the non-complying plan does not provide the information needed by the complying plan to determine its benefits within a reasonable time after it is requested to do so, the complying plan shall assume that the benefits of the non-complying plan are identical to its own, and shall pay its benefits accordingly. If, within

two (2) years of payment, the complying plan receives information as to the actual benefits of the non-complying plan, it shall adjust payments accordingly.

If the non-complying plan reduces its benefits so that the covered person receives less in benefits than the covered person would have received had the complying plan paid or provided its benefits as the secondary plan and the non-complying plan paid or provided its benefits as the primary plan, then the complying plan shall advance to the covered person or on behalf of the covered person an amount equal to the difference. In no event may the complying plan advance more than the complying plan would have paid had it been the primary plan less any amount it previously paid for the same expense or service. In consideration of the advance, the complying plan shall be subrogated to all rights of the covered person against the non-complying plan. The advance by the complying plan shall also be without prejudice to any claim it may have against a non-complying plan in the absence of subrogation.

- g. **Paying of claim where plans disagree on order of benefits.** If the plans cannot agree on the order of benefits within *thirty (30)* calendar days after the plans have received all of the information needed to pay the claim, the plans shall immediately pay the claim in equal shares and determine their relative liabilities following payment. However, no plan is required to pay more than it would have paid had it been the primary plan.

Effect of COB on the Benefits of this Plan

1. **When This Section Applies.** This section applies when, in accordance with the “*Order of Benefit Determination Rules*,” section above. When this plan is secondary, it may reduce benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total Allowable Expenses.
2. **Reduction in this Plan’s Benefits.** When this Plan is secondary, this Plan will calculate benefits it would have paid in the absence of other health coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. We will then reduce our payment by the amount so that when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, as the secondary plan, we shall credit to our plan deductible any amount we would have credited to the deductible in the absence of other health coverage.
 - i. If a Member is enrolled in two or more closed panel plans and if, for any reason, including the provision of services by a non-Participating Provider, benefits are not payable by one closed panel plan; COB shall not apply between this plan and any other closed panel plans.
3. **Plan’s Right to Receive and Release Needed Information.** Certain facts are needed to apply these COB rules. The Plan has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or persons for the purpose of applying these rules and determining benefits payable under this Plan. The Plan need not tell, or get the consent of any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to apply those rules and determine benefits payable.
4. **Facility of Payment.** A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it was a benefit paid under this Plan. The Plan will not have to pay that amount again. The term “payment made” includes providing benefits in the form of services, in which case “payment made” means reasonable cash value of the benefits provided in the form of services.
5. **Right of Recovery.** If the amount of the payments made by the Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of:
 - a. the persons it has paid or for whom it has paid;
 - b. insurance companies; or
 - c. other persons or organizations.The “amount of the payments made” includes the reasonable cash value of any benefits provided in the form of services.

Calculation of Benefits, Secondary Plan

Sanford Health Plan uses the *Preservation of Benefits* method for determining payments as a secondary payer.

If Sanford Health Plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans for any claim or claims are not more than *one hundred percent (100%)* of total allowable expenses. In determining the amount of a claim to be paid by Sanford Health Plan, should The Plan wish to coordinate benefits, it shall calculate the benefits it would have paid in the absence of other insurance and apply that calculated amount to any allowable expense under The Plan that is unpaid by the primary plan. Sanford Health Plan may reduce its payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim.

Coordination of Benefits with Medicare

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

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

Members with End Stage Renal Disease (ESRD)

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

SECTION 9. SUBROGATION AND RIGHT OF REIMBURSEMENT

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

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

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

Plan's Rights of Subrogation

In the event of any payments for benefits provided to a Member under this Contract, the Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member, his parents, heirs, guardians, executors, or other representatives may have against any person or organization. These subrogation and reimbursement rights also include the right to recover from uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, automobile medical payments coverage, premises medical expense coverage, and workers compensation insurance or substitute coverage. The Plan shall be entitled to receive from any such recovery an amount up to the Reasonable Cost for the services provided by the Plan. In providing benefits to a Member, the Plan may obtain discounts from its healthcare Providers, compensate Providers on a capitated basis or enter into other arrangements under which it pays to another less than the Reasonable Costs of the benefits provided to the Member. Regardless of any such arrangement, when a Member receives a benefit under the Plan for an illness or injury, the Plan is subrogated to the Member's right to recover the Reasonable Costs of the benefits it provides on account of such illness or injury, even if those Reasonable Costs exceed the amount paid by the Plan.

The Plan is granted a first priority right to subrogation or reimbursement from any source of recovery. The Plan's first priority right applies whether or not the Member has been made whole by any recovery. The Plan shall have a lien on all funds received by the Member, his parents, heirs, guardians, executors, or other representatives up to the Reasonable Costs Charge for the Health Care Services provided and to be provided to the Member. The Plan may give notice of that lien to any party who may have contributed to the loss.

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

Plan's Right to Reduction and Reimbursement

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

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

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

Member's Responsibilities

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

Payment in Error

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

SECTION 10. DEFINITIONS OF TERMS WE USE IN THIS BROCHURE

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| Ambulatory Surgical Center | A lawfully operated, public or private establishment that: <ul style="list-style-type: none"> a. Has an organized staff of Providers; b. Has permanent facilities that are equipped and operated mostly for performing surgery; c. Has continuous Provider's services and Nursing Services when a patient is in the Facility; and d. Does not have services for an overnight stay. |
| Authorized Representative | A person to whom a covered person has given express written consent to represent the Member, a person authorized by law to provide substituted consent for a Member, a family member of the Member or the Member's treating health care professional if the Member is unable to provide consent, or a health care professional if the Member's Plan requires that a request for a benefit under the plan be initiated by the health care professional. For any Urgent Care Request, the term includes a health care professional with knowledge of the Member's medical condition. |
| Billed Charge | The amount a Provider bills for all services and supplies, whether or not the services and supplies are covered under this policy. |
| Calendar Year | A period of one year which starts on January 1st and ends December 31 st . |
| Case Management | A coordinated set of activities conducted for individual patient management of serious, complicated, protracted, or other health conditions. |
| Certification | Certification is a determination by the Plan that a request for a benefit has been reviewed and, based on the information provided, satisfies the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness. |
| Coinsurance | The percentage of charges to be paid by a Member for Covered Services. Coinsurance payments begin once you meet any applicable deductible. |
| Concurrent Review | 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. |
| [This] Contract or [The] Contract | This Policy, including your application for coverage and any riders or amendments, constitutes your entire Contract of insurance. |
| Copay | An amount that a Member must pay at the time the Member receives a Covered Service. |
| Covered Services | Those Health Care Services to which a Member is entitled under the terms of This Contract. |
| Creditable Coverage | Benefits or coverage provided under: <ul style="list-style-type: none"> a. Medicare or Medicaid; b. An employer-based health insurance plan or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a health benefit plan; c. An individual health insurance policy; d. Chapter 55 of Title 10, United States Code; e. A medical care program of the Indian Health Service or of a tribal organization; f. A state health benefits risk pool; g. A health plan offered under Chapter 89 of Title 5, United States Code; h. A public health plan; i. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504)(e)); j. A church plan; k. A college plan; or l. A short-term limited-duration policy. |
| Deductible | The amount that a Member must pay each Calendar Year before the Plan will pay benefits for Covered Services. The following amounts will not apply towards the deductible: <ul style="list-style-type: none"> a. Copayments; b. Amounts for services that are not medically necessary; c. Amounts for Non-Covered Services as defined by this Policy; d. Amounts that have exceeded the Contract maximums; e. Any difference between the covered charges and the Reasonable Costs if you receive services from a Non-Participating Provider; and f. Amounts for services that are not properly Prior-Authorized/Certified. |
| Dependent | The Spouse and any Dependent Child of a Subscriber. |

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| Dependent Child | <ul style="list-style-type: none"> a. A Subscriber’s biological child; b. A child lawfully adopted by the Subscriber or in the process of being adopted, from the date of placement; c. A stepchild of the Subscriber; or d. A foster child or any other child for whom the Subscriber has been granted legal custody. |
| Eligible Dependent | Any “Dependent” who meets the specific eligibility requirements of the Plan. |
| Eligible Individual | Any individual who meets the specific eligibility requirements of this Plan. |
| Emergency Medical Condition | Sudden and unexpected onset of a health condition that requires immediate medical attention, if failure to provide medical attention would result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person’s health in serious jeopardy. |
| ESRD | The federal End Stage Renal Disease program. |
| Experimental or Investigational Services | Any Health Care Services where the Health Care Service in question either: <ul style="list-style-type: none"> a. is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or b. requires approval by any governmental authority and such approval has not been granted prior to the service being rendered. |
| Facility | An institution providing Health Care Services or a health care setting, including Hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings. |
| Health Care Services | Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease. |
| Hospital | A place licensed or recognized as a general rehabilitation or psychiatric Hospital by the proper authority of the state in which it is located. The term “Hospital” specifically excludes rest homes, places which are primarily for the care of convalescents, nursing homes, skilled nursing facilities, intermediate care facilities, health resorts, clinics, Physician’s offices, private homes, Ambulatory Surgical Centers, residential or transitional living centers, or similar facilities. |
| Hospitalization | A stay as an inpatient in a Hospital. Each “day” of Hospitalization includes an overnight stay for which a charge is customarily made. |
| Iatrogenic Condition | Illness or injury as a result of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error. |
| Intensive Outpatient Program (IOP) | Weekly structured programs for education and counseling for alcohol, drugs or gambling problems. Programs may be available in the evenings or weekends. |
| Lifetime Maximum | The amount each Member is eligible to receive for covered services in his/her lifetime. Lifetime benefits area accumulated from claims settled under this policy and any other individual coverage policies or policies issued in the State of South Dakota by Sanford Health Plan. This Policy includes an overall lifetime benefits maximum, which includes dollar and day maximums for certain services. |
| Medically Necessary | Health Care Services that are appropriate, in terms or type, frequency, level, setting, and duration, to the Member’s diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must: <ul style="list-style-type: none"> a. be consistent with generally accepted standards of medical practice as recognized by the Plan, as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and b. help restore or maintain the Members health; or c. prevent deterioration of the Member’s condition; or d. prevent the reasonably likely onset of a health problem or detect an incipient problem; or e. not considered Experimental or investigative |
| Member | Any individual who is enrolled in the Plan. |
| Mental Health and Chemical Dependency Services | Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association (DSM), current edition. |
| Natural Teeth | Teeth which are whole and without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury. |
| Non-Covered Services | Health Care Services that are not Covered. |

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| Non-Participating Provider | A Provider has not signed such a contract with the Plan. |
| Nursing Services | Health Care Services which are provided by a registered nurse (RN), licensed practical nurse (LPN), or other licensed nurse who is: (1) acting within the scope of that person's license, (2) authorized by a Provider, and (3) not a Member of the Member's immediate family. |
| Out-of-Network Benefit Level | The lower level of benefits provided by The Plan, as defined in the attached Summary of Payment., when a Member seeks services from a Non-Participating Provider without Plan Certification. |
| Out-of-Pocket Maximum | The maximum amount you pay, out of your pocket, for most covered services in a calendar year. |
| Participating Provider | A Practitioner and/or Provider who, under a contract with the Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, directly or indirectly, from the Plan. |
| Partial Hospital Program | Also known as Day Treatment for mental health and Chemical Dependency Services mean a group-oriented treatment setting based on an intermediate level of care usually held during the daytime hours generally providing twenty (20) or more hours of therapeutic activities per week. |
| Physician | An individual licensed to practice medicine or osteopathy. |
| [The] Plan | Sanford Health Plan. |
| Practitioner | A professional who provides health care services. Practitioners are usually required to be licensed as required by law. |
| Pre-Existing Condition | A physical or mental condition (including chemical dependency or alcoholism), regardless of the cause of the condition, for which: <ul style="list-style-type: none"> a. medical advice, diagnosis, care, or treatment was recommended or received during the <i>six (6)</i> month period before the effective date of this Policy. The effective date is the first day of coverage or first day of the waiting period; or b. an ordinarily prudent person would have sought medical advise, diagnosis, care, or treatment, within the <i>six (6)</i> month period before the effective date of this Policy; or c. In the case of pregnancy, existed on the effective date of this Policy (however, the Pre-existing waiting period does not apply to complications of pregnancy). |
| Premium | The amount paid by the Subscriber on a monthly basis for coverage for Members under this Contract. |
| Preventive | Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan. |
| Prospective (pre-service) Review | Means urgent and non-urgent Utilization Review conducted prior to an admission or the provision of a health care service or a course of treatment. |
| Prudent Layperson | A person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek emergency medical treatment. |
| Primary Care Physician (PCP) | A Participating Physician who is an internist, family practice Physician, pediatrician, or obstetrician/gynecologist who is a Participating Provider and who has been chosen to be designated as a Primary Care Physician as indicated in the Provider Directory and may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Member. |
| Provider | An institution or organization that provides services for Plan Members. Examples of Providers include Hospitals and home health agencies. |
| Reasonable Costs | Those costs that do not exceed the lesser of: (a) negotiated schedules of payment developed by the Plan which are accepted by Participating Providers or (b) the prevailing marketplace charges. |
| Service Area | The geographic Service Area approved by the State's Division of Insurance. |
| Spouse | An individual who is a Subscriber's current lawful Spouse under the laws of This State. |
| Subscriber | An Eligible Member who is enrolled in the Plan. A Subscriber is also a Member. |
| [This] State | The State of South Dakota. |
| Utilization Review | A set of formal techniques used by the Plan to monitor and evaluate the medical necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Prospective (pre-service) Review, second opinion, Certification, Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review. |

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| Urgent Care Request | <p>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:</p> <ol style="list-style-type: none"> 1. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgement; or 2. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request. |
| Us/We | Refers to Sanford Health Plan |

SUMMARY OF PAYMENT

This page intentionally left blank. Please refer to your *Summary of Payment* which is attached to this Policy.