



## OUTLINE OF MEDICARE SELECT SUPPLEMENT COVERAGE

The Commissioner of Commerce of the state of Minnesota has established two categories of Medicare SELECT Supplements and minimum standards for each. Sanford Health Plan offers the Basic Plan, which has the least comprehensive coverage, and the Extended Basic Plan with the most comprehensive coverage. A Medicare SELECT Policy contains a restricted network on hospitals and outpatient surgery centers.

The <i>Basic</i> Plan covers	
<b>Hospitalization:</b>	Part A coinsurance plus coverage for 100% of all Part A eligible expenses not covered by Medicare for the calendar year, after the deductible.
<b>Skilled Nursing:</b>	Daily copayment amount of Part A eligible expenses for days 21 through 100.
<b>Blood (Part A &amp; B):</b>	First 3 pints of blood each year.
<b>Medical Expenses:</b>	Part B coinsurance or copay amount (20% of Medicare approved expenses) after the deductible.
<b>Foreign Travel Emergency:</b>	80% Foreign Travel Emergency Care
<b>Included Benefit Riders:</b>	Part A Medicare Deductible Part B Medicare Deductible 100% Part B Excess Expenses

The <i>Extended Basic</i> Plan includes all services listed above and the following additional benefits:	
<b>Additional Benefits:</b>	80% Foreign Travel Care Skilled Nursing Care, 80% coverage for 20 additional days per calendar year. Preventive Care Benefit At-home Recovery Benefit Out-of-Pocket Maximum of \$1,000 per calendar year.

**OUTLINE OF MEDICARE SELECT SUPPLEMENT PLAN COVERAGE**  
**BASIC MEDICARE SUPPLEMENT**  
**EXTENDED BASIC MEDICARE SUPPLEMENT**

**IMPORTANT INFORMATION READ YOUR MEMBERSHIP CONTRACT CAREFULLY**

This is an outline describing your contract's most important features. It does not give all the details of Medicare coverage. Contact your local Social Security office or consult *Medicare & You* (sent by Medicare) for more details of Medicare coverage. The membership contract is your insurance contract. You must read the contract itself to understand all of the rights and duties of both you and your insurance company. Sanford Health Plan is not connected with Medicare. This contract may not cover all your medical costs.

When you fill out the application for the new membership contract, be sure to answer all questions about your medical and health history truthfully and completely. Sanford Health Plan may cancel your contract and refuse to pay any claims if you leave out or falsify important medical information.

This contract provides an anticipated loss ratio of 87%. This means that, on the average, policyholders may expect that \$87.00 of every \$100.00 in premium will be returned in the form of benefits to the policyholder over the life of the contract.

**PREMIUMS AND RENEWABILITY**

Sanford Health Plan guarantees to renew this contract as long as the premium is paid on or before the due date or within the grace period and you continue to live within the plans' service area. This contract will not be cancelled or non-renewed on the grounds of the deterioration of your health.

**PREMIUMS**

We may change the premium rates if we change all contracts with the same form numbers in the state in which you live. We will provide you written notice 30 days in advance of any changes in premium due to a change in benefits or a new table of rates. Benefits under this contract that are designed to cover cost-sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible and coinsurance percentage factors.

**OTHER IMPORTANT INFORMATION**

For most Services, if Medicare denies a charge, the Health Plan must deny it too. There are exceptions for some benefits that are required by Minnesota state law.

The State of Minnesota provides counseling services through Senior LinkAge. You can contact Senior LinkAge at 1-800-333-2433 to receive advice concerning the purchase of Medicare Supplement policies and enrollment under Medicaid. Contact the Minnesota Department of Commerce at 1-800-657-3602 for information about other Medicare Supplement products available in Minnesota.

NOTICE TO BUYER: This contract does not cover prescription drugs. Prescription drugs can be a very high percentage of your medical expenses. Coverage for prescription drugs may be available to use by retaining existing coverage you may have or by enrolling in Medicare Part D. Please ask your agent for further details.

## MEMBER PREMIUM RATE

Type	Plan	Monthly Rate	Annual Rate
Non-Tobacco User	Basic Plan	\$105.93	\$1,271.16
	Extended Basic Plan	\$247.09	\$2,965.12
Tobacco User	Basic Plan	\$120.45	\$1,445.40
	Extended Basic Plan	\$281.02	\$3,372.20

NOTE: The Extended Basic Plan includes foreign travel medical services at 80% coverage, at-home recovery services and preventive care benefits.

## RIGHT TO RETURN MEMBERSHIP CONTRACT

If you are not satisfied with your contract for any reason, you may return it along with written notice of cancellation to your insurance agent or **Sanford Health Plan at P.O. Box 91110, Sioux Falls, SD 57109-1110.**

You may cancel your contract any time before midnight of the 10th day following the date of purchase. If the contract is a replacement policy, you may return the contract to us within 30 days after you receive it. Cancellation of your contract will make the policy void from its inception and we will treat the contract as if it had never been issued and will return your premium payments, including any applicable fees or charges, within 10 days after receiving notice of cancellation.

If you are replacing another health insurance policy or certificate, do NOT cancel it until you have actually received your new membership contract and are sure you want to keep it. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

This contract does not cover all medical expenses beyond those covered by Medicare. This contract does not cover all skilled nursing home care expenses and does not cover custodial or residential nursing care. Read your contract carefully to determine which nursing home facilities and expenses are covered by your contract.

**NOTICE:**

**Items in brackets “[ ]” follow current Medicare amounts. This Policy may not fully cover all of your medical costs nor does it give all the details of Medicare coverage. Contact your Social Security Office or consult the “Medicare and You Handbook” for more details.**

Sanford Health Plan offers Medicare Supplement plans which do not restrict your use of hospital or surgery centers. You have the right to purchase Basic and Extended Basic Plans at anytime.

Neither Sanford Health Plan nor its agents are connected to Medicare.

**THE PLAN'S SERVICE AREA**

To be eligible to join Sanford Health Plan, you must live in one of these Minnesota counties: Cottonwood, Jackson, Lac Qui Parle, Lincoln, Lyon, Martin, Nobles , Murray, Pipestone, Redwood, Rock, Watonwan, or Yellow Medicine.

**COMPLETING THE APPLICATION**

**Complete answers are very important:** When completing the application for coverage, your signature verifies that you understand and agree that we will act reliance upon the information you have provided herein. When you fill out the application, be sure to answer truthfully and completely all questions about your medical health history. Sanford Health Plan may cancel your policy and refuse to pay any claims if you leave out or falsify important medical information. **NOTE:** If your policy is guranteed issue, this statment does not apply. Review the application carefully before you sign it. Be certain that all information has been properly recorded.

**PROVIDER NETWORK**

This is a Medicare SELECT supplement insurance policy. Facility expenses will be denied if you receive inpatient hospitalization services or outpatient surgery services in a non-participating, non-network facility. The full benefits of your coverage will be paid if:

1. Inpatient hospitalization and outpatient surgery services are received at a SELECT network facility;

2. Services are provided in the physician's office, in another office setting, or in a skilled nursing facility (network limitations do not apply);
3. Services are not available at a SELECT network facility; or
4. Emergency services are required: a) while traveling outside the SELECT service area or b) while inside the service area it is not reasonable to obtain emergency services through a SELECT network facility.

The Sanford SELECT Plan gives you the freedom to use traditional Medicare fee-for-service benefit when using facilities outside the plan's SELECT network. Please remember when you use this option; you are responsible for the Medicare deductibles, coinsurance and any applicable copay amounts.

## BENEFIT SUMMARY

Sanford Health Plan offers you two coverage options: the Basic Plan and the Extended Basic plan. The following summarizes your coverage, and how they compare to your benefits under standard Medicare. For detailed coverage terms and conditions, consult your Policy, or call Member Services at (605) 328-6800 or 1-800-752-5863.

<b>BASIC PLAN</b>			
<b>MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD</b>			
Services	Medicare Pays	Sanford Basic Plan Pays	You Pay
<b>HOSPITALIZATION*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$[1,068] deductible	\$[1,068] Part A deductible	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$[267] a day	\$[267] a day	\$0
91 <sup>st</sup> day and after	All but \$[534] a day	\$[534] a day	\$0
<ul style="list-style-type: none"> <li>▪ While using 60 lifetime reserve days</li> </ul>	All but \$[534] a day	\$[534] a day	\$0
<ul style="list-style-type: none"> <li>▪ Beyond the additional 150 days</li> </ul>	\$0	100% of Medicare Eligible Expenses	\$0
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare’s requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101 <sup>st</sup> day and after	\$0	\$0	All costs

\*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled in care in any other facility for 60 days in a row.

\*\*Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

\*\*\*Part B Coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient services under a prospective payment system, applicable copay amounts.

Services	Medicare Pays	Sanford Basic Plan Pays	You Pay
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for inpatient respite care.	\$0	Balance
<b>MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR</b>			
<b>MEDICAL EXPENSES</b> Inpatient and outpatient hospital treatments such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostics tests, durable medical equipment  First \$[135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts Part B Excess Charge (above Medicare Approved Amounts)	\$0 80% \$0	\$[135] Part B Deductible 20%*** 100%	\$0 \$0 \$0
<b>BLOOD</b> First 3 pints  Next \$[135] of Medicare Approved Amounts**  Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$[135] Part B Deductible 20%	\$0 \$0 \$0

\*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled in care in any other facility for 60 days in a row.

\*\*Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

\*\*\*Part B Coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient services under a prospective payment system, applicable copay amounts.

Services	Medicare Pays	Sanford Basic Plan Pays	You Pay
<b>CLINICAL LABORATORY SERVICES</b> Tests for Diagnostic Services	100%	\$0	\$0
<b>MEDICARE PARTS A &amp; B</b>			
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies	100%	\$0	\$0
Durable Medical Equipment First \$[135] of Medicare Approved amounts**	\$0	[\$135] Part B Deductible	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
<b>FOREIGN TRAVEL</b> NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during travel outside the United States (hospital, medical expense and supplies)	\$0	80% of covered expenses	Expenses not paid by Medicare or this policy
<b>PREVENTIVE MEDICAL CARE BENEFIT</b> FOR SERVICES NOT COVERED BY MEDICARE First \$120 each calendar year Additional Charges	\$0 \$0	\$0 \$0	\$120 All costs

\*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled in care in any other facility for 60 days in a row.

\*\*Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

\*\*\*Part B Coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient services under a prospective payment system, applicable copay amounts.

**EXTENDED BASIC PLAN  
MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD**

Services	Medicare Pays	Sanford Extended Basic Plan Pays	You Pay
<b>HOSPITALIZATION*</b>			
Semi-private room and board, general nursing and miscellaneous services and supplies.			
First 60 days	All but \$[1,068] deductible	\$[1,068] Part A deductible	\$0
61 <sup>st</sup> through 90 <sup>th</sup> day	All but \$[267] a day	\$[267] a day	\$0
91 <sup>st</sup> day and after	All but \$[534] a day	\$[534] a day	\$0
<ul style="list-style-type: none"> <li>▪ While using 60 lifetime reserve days</li> <li>▪ Beyond the additional 150 days</li> </ul>	\$0	100% of Medicare Eligible Expenses	\$0
<b>SKILLED NURSING FACILITY CARE*</b>			
You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	\$0	\$0
21 <sup>st</sup> through 100 <sup>th</sup> day	All but \$[133.50] a day	Up to \$[133.50] a day	\$0
101 <sup>st</sup> day and after	\$0	80% of covered expenses up to 120 days per calendar year	All costs

\*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled in care in any other facility for 60 days in a row.

\*\*Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

\*\*\*Part B Coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient services under a prospective payment system, applicable copay amounts.

Services	Medicare Pays	Sanford Extended Basic Plan Pays	You Pay
<b>BLOOD</b> First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
<b>HOSPICE CARE</b> Available as long as your doctor certifies you are terminally ill and you elect to receive these services.	All but very limited coinsurance for inpatient respite care	\$0	Balance
<b>MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR</b>			
<b>MEDICAL EXPENSES</b> In or out of the hospital and outpatient hospital treatments such as physician’s services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostics tests, durable medical equipment			
First \$[135] of Medicare Approved Amounts**	\$0	\$[135] Part B Deductible	\$0
Remainder of Medicare Approved Amounts	80%	20%***	\$0
Part B Excess Charge (above Medicare Approved Amounts)	\$0	100%	\$0
<b>BLOOD</b> First 3 pints Next \$[135] of Medicare Approved Amounts** Remainder of Medicare Approved Amounts	\$0 \$0 80%	All costs \$[135] Part B Deductible 20%	\$0 \$0 \$0
<b>CLINICAL LABORATORY SERVICES</b> Tests for Diagnostic Services	100%	\$0	\$0

\*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled in care in any other facility for 60 days in a row.

\*\*Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

\*\*\*Part B Coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient services under a prospective payment system, applicable copay amounts.

MEDICARE PARTS A & B			
Services	Medicare Pays	Sanford Extended Basic Plan Pays	You Pay
<b>HOME HEALTH CARE</b> MEDICARE APPROVED SERVICES Medically necessary skilled care services and medical supplies Durable Medical Equipment	100%	\$0	\$0
First \$[135] of Medicare Approved amounts**	\$0	[\$135] Part B Deductible	\$0
Remainder of Medicare Approved amounts	80%	20%	\$0
<b>HOME HEALTH CARE</b> AT HOME RECOVERY SERVICES NOT COVERED BY MEDICARE Home care certified by your doctor for personal care during recovery from an injury or sickness for which Medicare approved a Home Care Treatment Plan			
Benefit for each visit	\$0	Actual charges to \$100.00 per visit	Balance
Number of visits covered (must be received within 8 weeks of last Medicare approved visit)	\$0	Up to the number of Medicare Approved visits (limited to 7 each week)	Balance
Calendar Year Maximum	\$0	[\$4,000]	Balance

\*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled in care in any other facility for 60 days in a row.

\*\*Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

\*\*\*Part B Coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient services under a prospective payment system, applicable copay amounts.

Services	Medicare Pays	Sanford Extended Basic Plan Pays	You Pay
<b>FOREIGN TRAVEL</b> NOT COVERED BY MEDICARE Medically necessary services during travel outside the United States	\$0	80% of covered expenses	Expenses not paid by Medicare or this policy
<b>PREVENTIVE MEDICAL CARE BENEFIT FOR SERVICES NOT COVERED BY MEDICARE</b>  First \$120 each calendar year	\$0	\$120	\$0
Additional Charges	\$0	\$0	All costs

\*A benefit period begins on the first day you receive services as an inpatient in a hospital and ends after you have been out of the hospital and have not received skilled in care in any other facility for 60 days in a row.

\*\*Once you have been billed \$135 of Medicare Approved Amounts for covered services, you Part B Deductible will have been met for the calendar year.

\*\*\*Part B Coinsurance (generally 20% of Medicare approved expenses), or in the case of hospital outpatient services under a prospective payment system, applicable copay amounts.

## **ADDITIONAL BENEFITS UNDER THE BASIC AND EXTENDED PLANS**

1. **Alcoholism. Chemical Dependency. Drug Addiction.** When you receive treatment in a licensed hospital, residential treatment program or nonresidential treatment program for alcoholism, chemical dependency or drug addiction, we will pay benefits on the same basis as coverage for any other condition. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of your policy.
2. **Scalp Hair Prosthesis.** We will pay the expense incurred on the same basis as any other sickness or injury and as if Medicare paid benefits for a scalp hair prosthesis needed because of hair loss suffered as a result of alopecia areata. Only the first \$350.00 of expense incurred in a calendar year will be considered as expense under this part of your policy. Amounts in excess of the reasonable charge are not considered expense. Benefits are not payable for that portion of expense that is paid by Medicare or paid under any other part of this policy.
3. **Routine Screening Procedures for Cancer.** We will pay the expense incurred that is not paid by Medicare or paid *under* any other part of your policy for routine screening procedures for cancer and the office or facility visit charge. Procedures include screening mammograms, Pap smears colorectal screening tests and ovarian cancer surveillance tests.
4. **Temporomandibular Joint Disorder (TMJ) and Craniomandibular Disorder.** Benefits are payable for the surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder on the same basis as that for treatment to any other joint in the body. Such treatment must be administered or prescribed by a physician or dentist. Benefits are not payable under this part of your policy for any expense payable under another part of the policy.
5. **Reconstructive Surgery.** Benefits are payable for reconstructive surgery on the same basis as that for any other surgery if the reconstructive surgery is incidental to or follows surgery resulting from injury, sickness or other disease of the involved part. Benefits are not payable under this policy for an expense payable under another part of the policy.
6. **Surgical Center Services.** Benefits are payable for surgical center services for health care treatment or service rendered by a freestanding ambulatory surgical center or facilities offering ambulatory medical service 24 hours a day, 7 days a week, which are not part of a hospital, but have been reviewed and approved by the state Commissioner of Commerce to provide the treatment or service on the same basis as coverage provided for the same health care treatment or service rendered by a hospital. Benefits are not payable under this part of your policy for an expense payable under another part of the policy.
7. **Immunization Benefits.** We will pay the expense incurred for an immunization received by you. Benefits are not payable for that portion of expense for which benefits were paid by Medicare or under any other portion of the policy.
8. **Phenylketonuria (PKU) Treatment.** Benefits are payable for special dietary treatment for phenylketonuria when recommended by a physician.
9. **Diabetes Equipment and Supplies.** We will pay the reasonable charge for expense incurred for all Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, not otherwise covered under Medicare or Part D of the Medicare Program. Coverage must include persons with gestational, type I, or type II diabetes. Benefits will be limited to 80% of the reasonable charge not covered by Medicare or Part D of the Medicare Program.

10. **Routine Prostate Cancer Screening.** We will pay the expense incurred for prostate cancer screening. Benefits are limited to at least one screening per year for any insured male 50 years of age or older; and at least one screening per year for any insured male 40 years of age or older who is symptomatic.
11. **Mental Health Coverage.** For outpatient mental health care we will pay the allowable amount not paid by Medicare, less the Part B Deductible if applicable. Medicare limits apply. For inpatient mental health care we will pay benefits on the same basis as coverage for any other condition.
12. **Physical and Occupational Therapy Services.** We will pay the allowable amount not paid by Medicare, less the Part B Deductible if applicable.
13. **Treatment of Lyme Disease.** We will pay benefits for diagnosed Lyme disease as any other medical service. Benefits will not be payable for that portion of expense that is paid by Medicare or under any other part of your policy.

### **ADDITIONAL BENEFITS UNDER THE EXTENDED PLAN**

Sanford Health Plan will pay 80% of the reasonable cost for the following services and supplies prescribed by a physician which are not paid by Medicare or payable under any other provision of your policy.

1. Hospital services.
2. Professional services of the diagnosis or treatment of injuries, sickness or conditions when such services are given by a physician or are under a physician's direction. Outpatient mental or dental services are not covered.
3. Services of a nursing home for not more than 120 days each year. Such services must qualify as reimbursable under Medicare.
4. Use of radium or other radioactive materials.
5. Oxygen.
6. Anesthetics.
7. Prosthetic devise other than dental appliances.
8. Rental or purchase, as appropriate, of durable medical equipment other than eye glasses and hearing aids.
9. Diagnostic X-rays and laboratory tests.
10. Oral surgery for: a) partially or completed unerupted impacted teeth, b) a tooth root without the extraction of the entire tooth or c) the bums or tissues of the mouth when not performed in connection with the extraction or repair of teeth.
11. Services of a physical therapist.
12. Professional ambulance for service to the nearest facility qualified to treat the condition, or a reasonable mileage rate for transportation to a kidney dialysis center for treatment.
13. Well-baby care.
14. Up to \$500.00 for a second surgical opinion, excluding charges for the repetition of diagnostic tests.
15. Services of an occupational therapist.

## **EXCLUSIONS AND LIMITATIONS**

**This is a summary of items that are excluded from coverage. In addition to any other benefit exclusions or limitations specified in your Policy, Sanford Health Plan will not cover charges incurred for any of the following services.**

1. Charges for inpatient and preventive care services received from a non-participating SELECT provider. Please read the contract language carefully to determine specific benefits and coverage.
2. Outpatient prescription drugs, except as specifically described in your Policy and except for certain drugs as covered by Medicare.
3. Eyewear (except as described in your Medicare Handbook), hearing aids or dentures.
4. Personal comfort items during hospital stays, for example, internet service or movies.
5. Private Duty Nursing.
6. Custodial nursing home care or intermediate nursing home care.
7. Inpatient mental health care in a Medicare-certified psychiatric hospital beyond Medicare's 190 day lifetime limit.
8. Hospital stays for "rest cures" or convalescence in a nursing home.
9. Cosmetic or reconstructive surgery except when those services are incidental to or follow surgery of an injury or illness of the affected body part.
10. Examinations for insurance or employment screening.
11. Transportation, except as specifically described in your Policy, and lodging or living expenses incidental to travel.
12. Health services that do not meet Medicare criteria, except those specifically described as covered in your Policy.
13. Physician charges above Medicare's approved charges, except as described in the Extended Basic Policy.
14. Any charge for care for injury or disease either a) arising out of an injury in the course of employment and subject to a workers' compensation or similar law, b) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or c) for which benefits are payable under another policy of accident and health insurance, Medicare or any other governmental program.
15. Any charge for confinement in a private room to the extent it is in excess of the institution's charge for its most common semi-private room, unless a private room is prescribed as medically necessary by a physician, provided however, that if the institution does not have semiprivate rooms, its most common semiprivate room charges shall be considered to be 90% of its lowest private room charge.
16. Part of any charge for services or supplies provided by or prescribed by a physician, dentist, or other health care professional which exceed the prevailing charge in the locality where the service is provided.
17. Any charge for services or supplies which are not within the scope of authorized practice of the institution or individual providing the services.

## **DISPUTES AND COMPLAINTS**

We have a complaint procedure to resolve claims and disputes between or on behalf of members and applicants. Complaints should be made in writing or orally. They may be medical or nonmedical in nature, or may concern the provision of care, administrative actions, or claims related to this Contract. Our member complaint system is limited to members, applicants, former members, or anyone acting on behalf of a member, applicant or former member seeking to resolve a dispute which arose during their membership or application for membership.

### **Complaints must be sent or directed to:**

Sanford Health Plan  
Attn: Member Services Department  
P.O. Box 91110  
Sioux Falls, SD 57109-1110

Telephone: (605) 328-6800  
Toll-free: 1-800-752-586

### **Medicare reconsideration process:**

If your complaint involves a dispute relating to the payment of services covered by *Medicare*, you may file a *Medicare* appeal through *Medicare*, not Sanford Health Plan. The steps to follow in filing a *Medicare* reconsideration are explained in the *Explanation of Medicare Benefits* that can be obtained from the *Medicare* carrier. You may also contact the Social Security Office at 1-800-772-1213.

### **For coverage issues related to enrollment, termination, premium payments or coverage of *Medicare* non-eligible services.**

You may direct any question or complaint to Member Service at (605) 328-6888 or 1-800-715-8419. Hearing impaired members with a TTY phone may contact Member Service at (605) 328-6869. You may also direct complaints at any time to the Commissioner of Commerce, Minnesota Department of Commerce at (651) 296-2488 or 1-800-657-3602.

Filing a complaint may require that Sanford Health Plan review your medical records as needed to resolve your complaint.

If your complaint is regarding an initial decision made by Sanford Health Plan, your complaint must be made within one year following Sanford Health Plan's initial decision.

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**Informal Complaints:**

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

**Formal Complaint Process:**

A Member can seek further review of a complaint not resolved through the formal process. You or your authorized representative may send your written request for review, including comments, documents, records and other information relating to the complaint, the reasons you believe you are entitled to benefits and any other supporting documents to:

Sanford Health Plan of Minnesota  
Member Services Department  
P.O. Box 91110  
Sioux Falls, SD 57109-1110

We will notify the Member within 10 business days that we received the written complaint, unless the complaint has been resolved to the Member's satisfaction within those 10 business days.

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your complaint. We will review your complaint and notify you of our decision in accordance with the following timelines:

**For Pre-Service Claims (services for which prior approval by us is a requirement for coverage)** If the request concerns urgent care, you may request an expedited review either orally or in writing. Within 72 hours of such request, a decision on your complaint will be made. If the request concerns non-urgent services, a decision on your request will be made within 30 calendar days from the date the Plan receives your request. In certain circumstances, this time period may be extended 14 additional days. In such cases the Plan will notify you in advance, of the reasons for the extension.

**Pre-Service Authorizations requiring Utilization Review for Medical Determinations** If the service request requires *utilization review* for a medical determination, you may request a review either orally or in writing.

**Urgent Request** If the service request is urgent, you may request an expedited review. Within 72 hours of such request, a decision will be made via telephone to you and your provider. You and your provider will receive written notification within 1 calendar day of the decision.

**Non-Urgent Request** If the service request concerns non-urgent services, a written decision will be made within 10 business days from the date the Plan receives your request. If the decision is not to certify your request, telephone notification will be made within 1 calendar day to you and your provider.

**Post-Service Claims.** A decision on your complaint will be made within 30 calendar days from the date the Plan receives your request. This time period may be extended if you agree.

### **Appeal Process:**

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

**Post-service appeal.** If after the first level of complaint review of a post-service claim, your request was denied, you or your authorized representative may submit a written request for appeal, including any relevant documents, and submit issues, comments and additional information as appropriate to:

Sanford Health Plan of Minnesota  
Member Services Department  
P.O. Box 91110  
Sioux Falls, SD 57109-1110

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

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

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

**Pre-service and concurrent appeal (for utilization review for a medical determination).**

When an initial determination is to deny your request, you or your authorized representative may submit a request for appeal. You may request an expedited review either orally or in writing. Within 72 hours, or as expeditiously as the Member's medical condition requires, of such request, a decision on your complaint will be made via telephone to you and your provider. If the decision is to deny your request, you and your provider will receive written notification of the decision and your right to initiate the external appeals process as soon as practical.

If the complaint concerns non-urgent, services, a written decision on your complaint will be made within 30 calendar days from the date the Plan receives your request. In certain circumstances, this time period may be extended 14 additional days. In such cases the Plan will notify you in advance, of the reasons for the extension.

**External Complaint Procedures:**

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



**Sanford**  
Health Plan of Minnesota

Member Services (605) 328-6800

Toll-free: 1-800-752-5863

[sanfordhealthplan.com](http://sanfordhealthplan.com)