South Dakota

Policy

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SANFORD
HEALTH PLAN

WELCOME TO SANFORD HEALTH PLAN

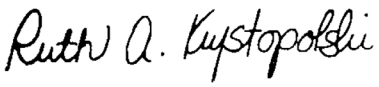
Welcome to Sanford Health Plan (hereinafter referred to as "The Plan"). We are pleased to have you as a Member and look forward to providing you and your enrolled dependents with health care services. The Plan is proud of the fact that we not only manage your health care, but also provide you with an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

This is your new Policy, which explains each feature of your coverage. This Certificate replaces any prior Certificates you may have had. Your Policy is the legal document representing your coverage, so please keep it in 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. The Plan's Medical Management Program monitors utilization and coordinates care plans to ensure that our Members are receiving the most appropriate care. Also, prevention and wellness programs are built into the benefit package. This encourages Members to seek treatment early and to live healthier lifestyles, thereby controlling long-term health care costs.

The key to our success is our network of primary care physicians, specialists and hospitals. In partnership with these health care Practitioner and/or Providers, the Plan actively promotes health care education, prevention and early detection. Together, we understand the need to deliver the best possible patient care, maintaining good community health, while developing cost-effective solutions. Plan Members have access to hundreds of area physicians and a hospital network that includes the region's most commendable *tertiary* care facility – Sanford USD Medical Center. 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, for the right reason.



Ruth A. Krystopolski
Vice President, Managed Care Services
Sanford Health Plan

Amendment to Your South Dakota Health Benefits Policy Small & Large Group

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SANFORD HEALTH PLAN

This Amendment is effective January 1, 2012 and applies to your group health benefits Policy dated January 2006. Please review this document carefully and keep it with your Policy for future reference.

Section 3(a) of your Policy, *Transplants*, is amended by deleting the section in its entirety and replacing with the following:

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

Transplants that meet the United Network for Organ Sharing (UNOS) criteria and/or Plan policy requirements and are performed at Plan Participating Providers or contracted centers of excellence for the following conditions are covered.

Coverage is provided the organ donor expenses under the transplant recipient's benefit plan when the billed under the transplant recipient's name when the recipient of the transplant meets ALL of the following criteria:

- Is eligible for coverage under the Plan
- Has a condition for which the proposed transplant is considered medically necessary
- Meets the Plan's medical coverage guidelines for transplant
- The charges are not covered by the donor's own benefit plan, by another group health plan or other coverage arrangement

Coverage is provided for transplants according to the Plan's medical coverage guidelines (available upon request) for the following services:

- Pre-operative care
- Transplant procedure, facility and professional fees
- Organ acquisition costs including:
- For living donors: organ donor fees, recipient registration fees, laboratory tests (including tissue typing of recipient and donor), and hospital services that are directly related to the excision of the organ
- For cadaver donors: operating room services, intensive care cost, preservation supplies (perfusion materials and equipment), preservation technician's services, transportation cost, and tissue typing of the cadaver organ
- Bone marrow or stem cell acquisition and short term storage during therapy for a Participant with a covered illness
- Short-term storage of umbilical cord blood for a Participant with a malignancy undergoing treatment when there is a donor match.
- Post-transplant care and treatment
- Drugs (including immunosuppressive drugs)
- Supplies (must be Prior Authorized)
- Psychological testing
- Living donor transplant-related complications for sixty (60) days following the date the organ is removed, if not otherwise covered by donor's own health benefit plan, by another group health plan or other coverage arrangement

The following transplants are eligible for coverage:

1. Kidney transplants for end stage disease
2. Cornea transplants for end stage disease

3. Heart transplants for end stage disease
4. Implantable ventricular assist device used while waiting for a heart transplant
5. Lung transplants or heart/lung transplants for:
    a. primary pulmonary hypertension;
    b. Eisenmenger's syndrome;
    c. end stage pulmonary fibrosis;
    d. alpha 1 antitrypsin disease;
    e. cystic fibrosis; and f
    f. emphysema for Participant's with specific indications.
6. Liver transplants for:
    a. biliary atresia in children;
    b. primary biliary cirrhosis;
    c. post acute viral infection (including hepatitis A, hepatitis B antigen E negative and hepatitis C causing acute atrophy or post necrotic cirrhosis);
    d. primary sclerosing cholangitis; and
    e. alcoholic cirrhosis.
7. Pancreas transplants (cadaver organ) for Participants with Type I uncontrolled diabetes for:
    a. simultaneous pancreas kidney;
    b. pancreas after kidney; and
    c. pancreas before kidney.
8. Allogenic bone marrow transplants or peripheral stem cell support (myeloablative or non-myeloablative) for:
    a. Acute Lymphoblastic Leukemia
    b. Acute Myelogenous Leukemia
    c. Chronic Myelogenous Leukemia
    d. Pediatric Neuroblastoma
    e. Myelodysplastic Diseases
    f. Hodgkin's Disease (Lymphoma)
    g. Non-Hodgkin's Lymphoma
    h. Genetic Diseases and Acquired Anemias:
        i. Sickle cell anemia
        ii. Severe aplastic anemia
        iii. Wiskott-Aldrich syndrome
        iv. Severe combined immunodeficiencies
        v. Mucopolysaccharidoses
        vi. Mucolipidoses
9. Autologous bone marrow transplants or peripheral stem cell support associated with high dose chemotherapy for:
    a. Acute Lymphoblastic Leukemia
    b. Acute Myelogenous Leukemia
    c. Chronic Myelogenous leukemia
    d. Pediatric Neuroblastoma
    e. Ewing's Sarcoma
    f. Primitive Neuroectodermal Tumors
    g. Germ Cell Tumors
    h. Multiple Myeloma
    i. Primary Amyloidosis
    j. Hodgkin's Disease (Lymphoma)
    k. Non-Hodgkin's Lymphoma
    l. Breast Cancer

Not covered:

- *Transplant evaluations with no end organ complications*
- *Storage of stem cells including storing umbilical cord blood of non-diseased persons for possible future use*
- *Artificial organs, any transplant or transplant services not listed above*

- *Expenses incurred by a Participant as a donor, unless the recipient is also a Participant Costs related to locating organ donors*
- *Donor expenses for complications that occur after sixty (60) days from the date the organ is removed, regardless if the donor is covered as a Participant under this Plan or not*
- *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 Sanford Health Plan's medical director or its designee*
- *Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating Provider or non-center of excellence*
- *Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria*

All other terms and provisions of your benefits policy, including any amendments we may have previously issued, remain unaltered and in effect.

Mandatory Amendment
Commercial Group
South Dakota

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SANFORD HEALTH PLAN

Despite language in the current Policy to the contrary, the following provisions apply under this Policy for plan years beginning on or after September 23, 2010 to ensure compliance with federal health care reform known as the Patient Protection and Affordable Care Act, including any amendments, regulations, rules or other guidance issued with respect to the act ("Act").

Lifetime Dollar Limits

Any Essential Health Benefits, as defined in the Act, provided within your Policy are not subject to any lifetime dollar limit. "Essential health benefits" include the following categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management and pediatric services, including oral and vision care. Any "per calendar year" or "per plan year" dollar limits may only be applied to essential benefits as allowed in the Act.

Rescissions

Current incontestability and rescission language is replaced with the following:
"Only an act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, made by an applicant for health insurance coverage may be used to void this application or policy and deny claims."

Extension of Coverage to Adult Dependents

Notwithstanding the eligibility requirements described in the Policy, an adult dependent is eligible to become a covered person if the dependent is under age twenty-six (26) and is related to you as a child. Coverage will continue to the end of the month the dependent child turns age twenty-six (26). Coverage does not include the spouse or child of such dependent unless that child meets other coverage criteria established under state law. The adult dependent's marital status, financial dependency, residency, student status or employment status will not be considered in determining eligibility for initial or continued coverage. For grandfathered groups, if the adult dependents is eligible for coverage under their own, or their spouse's, employer group plan (regardless of whether or not they enrolled in such coverage), they are not eligible for this extension of coverage.

Preexisting Conditions

The Preexisting Condition Exclusion provisions in Section 4 of your Policy does not apply to a covered person that is under the age of nineteen (19).

Preventive Services

The following preventive services, as defined in the Act, received from an in-network provider are covered without payment of any deductible, copayment, or coinsurance requirement that would otherwise apply:

1. evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
2. immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Covered Person involved;
3. with respect to covered persons who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. with respect to covered persons who are women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Emergency Treatment

Emergency services, as defined in your Policy, from Non-Participating Providers will be covered at the same benefit and cost sharing level as services provided by Participating Providers. If the Plan determines the condition did not meet prudent layperson definition of an emergency, then the out-of-network deductible and coinsurance amounts will apply and the member is responsible for charges above the reasonable cost.

Appeals

The following is inserted and amends Section 6 of your Policy entitled Problem Resolution.

You have the right to appeal an adverse benefit determination made by Sanford Health Plan through the internal appeals process. An adverse benefit determination includes a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit including any denial, reduction, termination, or failure to provide or make a payment (for pre-service or post service claims) that is based on:

a. A determination that a benefit is not a covered benefit;
b. The imposition of a preexisting condition exclusion, source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or
c. A determination that a benefit is experimental, investigational, or not medically necessary or appropriate.

A rescission is an adverse benefit determination.

Once an appeal is filed you will be provided free of charge a copy of "new evidence" that may apply and a rationale sufficiently in advance of the adverse determination so that you have time to respond. The claim or appeal decision maker assignment will be made so as to avoid conflict of interests in a manner designed to ensure the independence and impartiality of the persons involved in making a decision. We will respond to your request for appeal no later than seventy-two (72) hours after receipt of the claim if it is an urgent care situation. You have the right to contact the South Dakota Division of Insurance for additional information or assistance with your claim. We will provide you a copy of the complete appeals procedure upon request. If it is a concurrent review you will have continued coverage pending the outcome of an internal appeal.

External Review

The following provision replaces the Independent, External Review of Final Determinations language in Section 6 of your Policy.

You have the right to an external review of an adverse benefit determination within one-hundred-twenty (120) days after date of receipt of notice of an adverse determination. An adverse benefit determination is a determination by the Plan that an admission, availability of care, continued stay or other health care service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated.

The external review will be made by an independent review organization with health care professionals that have no conflict of interest with respect to the benefit determination. Except for approved expedited external reviews, this external review is available once you have exhausted the internal grievance process. You may request an external review by completing the *Request for External Review* form which may be obtained from us or from the South Dakota Division of Insurance. The South Dakota Division of Insurance upon application and approval of the request for external review will assign the external review organization. Upon request we will provide a copy of the full external review procedure. You may also contact the Division of Insurance for assistance or if you have questions.

NOTICE CONCERNING COVERAGE LIMITATIONS AND EXCLUSIONS UNDER THE SOUTH DAKOTA LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of South Dakota who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the South Dakota Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The Guaranty Association does not provide coverage for all types of life, health, or annuity benefits, and the Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in South Dakota. You should not rely on coverage by the South Dakota Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association for the purpose of sales, solicitation, or inducement to purchase any kind of insurance policy.

The South Dakota Life and Health Insurance Guaranty Association
Charles D. Gullickson, Executive Director
206 West 14th Street
Sioux Falls, South Dakota 57104
Tel. (605) 336-0177
www.sdlifega.org

South Dakota Division of Insurance
445 East Capitol, Pierre, South Dakota 57501-5070
Tel. (605) 773-3563
www.state.sd.us/dcr/insurance

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The state law that provides for this safety-net coverage is called the South Dakota Life and Health Insurance Guaranty Association Act. Below is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law, nor does it in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life or health insurance contract, or an annuity, or if they are an insured certificateholder under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state. Coverage is also provided by the Guaranty Association to persons eligible to receive payment under structured settlement annuities who are residents of this state and, under certain conditions, such persons even if they are not a resident of this state.

EXCLUSIONS FROM COVERAGE

However, persons holding such policies are **not** protected by the Guaranty Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer was not authorized to do business in this state;
- their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **not** provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;
- claims based on marketing materials or other documents which are not approved policy forms, claims based on misrepresentations of policy benefits, and other extra-contractual claims;
- any policy of reinsurance (unless an assumption certificate was issued);
- interest rate yields that exceed an average rate specified by statute;
- dividends;
- credits given in connection with the administration of a policy by a group contractholder;
- employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- unallocated annuity contracts (which give rights to group contractholders, not individuals);
- certain contracts which establish benefits by reference to a portfolio of assets not owned by the insurer.

LIMITS ON AMOUNT OF COVERAGE

The Guaranty Association in no event will pay more than what an insurance company would owe under a policy or contract. In addition, state law limits the amount of benefits the guaranty association will pay for any one insured life, and no matter how many policies or contracts there are with the same company, as follows: (i) for life insurance, not more than $300,000 in death benefits and not more than $100,000 in net cash surrender and net cash withdrawal values; (ii) for health insurance, not more than $500,000 for basic hospital, medical and surgical insurance, not more than $300,000 for disability insurance and long term care insurance, and not more than $100,000 for other types of health insurance; and (iii) for annuities, not more than $100,000 in the present value of annuity benefits, including net cash surrender and net cash withdrawal values. However, in no event will the Guaranty Association be obligated to cover more than an aggregate of $300,000 in benefits with respect to any one life except with respect to benefits for basic hospital, medical and surgical insurance, for which the aggregate liability of the guaranty association may not exceed $500,000. These general statements of the limits on coverage are only summaries and the actual limitations are set forth in South Dakota law.

ADDITIONAL INFORMATION

The statutes which govern the Guaranty Association are contained in SDCL Chapter 58-29C. Additional information about the Guaranty Association may be found at www.sdlifega.org, which contains a link to SDCL Chapter 58-29C.

Information about the financial condition of insurers is available from a variety of sources, including financial rating agencies such as AM Best Company, Fitch Inc., Moody's Investors Service, Inc., and Standard & Poor's. Additional information about financial rating agencies may be obtained by clicking on "Insurance Related Links" on the website of the South Dakota Division of Insurance at www.state.sd.us/dcr/insurance.

The Guaranty Association is subject to supervision and regulation by the director of the South Dakota Division of Insurance. Persons who desire to file a complaint to allege a violation of the statutes governing the Guaranty Association may contact the Division of Insurance. State law provides that any suit against the Guaranty Association shall be brought in Hughes County, South Dakota.

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Amendment II to Your South Dakota Large & Small Group Health Benefits Policy

This Amendment is effective April 1, 2009 and applies to your health Certificate of Coverage dated January 2006. Please review this document carefully and keep it with your Policy for future reference.

AMENDMENT #1	Section 1. Enrollment.

The provision titled, ***Special Enrollment Rights*** *is hereby revised and amended as follows:*

Special Enrollment Rights

Special enrollment rights apply when an individual becomes an Employee's Dependent through marriage, birth, adoption, or placement for adoption, and also when an Employee's Dependent loses health coverage. In order to special enroll an Eligible Employee's new Dependent, The Plan will require the Eligible Employee to be enrolled also. Special enrollment rights extend to all benefit packages available under The Plan. ~~Special enrollees are not treated as Late Enrollees subject to the pre-existing waiting period.~~

Any Eligible Group Member or Eligible Dependent who was not previously enrolled in the Plan and has lost prior coverage shall be able to enroll in the Plan within *thirty (30)* days after the date of exhaustion of the previous coverage provided that the following conditions are met:

1. **Waived Coverage.** The Eligible Group Member or Eligible Dependent was covered under a Group health plan or had health insurance coverage at the time coverage was initially (upon date of hire) offered to the Eligible Group Member or Eligible Dependent; or, after subsequently enrolling in other coverage, the Eligible Employee had an opportunity to enroll during the open enrollment period or at the time of a special enrollment period, but again chose not to enroll; and the Eligible Group Member stated in writing at such time that coverage under a Group health plan or health insurance coverage was the reason for declining enrollment (applicable only if the Group required such a statement at such time and provided the individual with notice of such requirement at such time).
2. **Exhausted COBRA.** The Eligible Group Member's or Eligible Dependent's previous coverage was under a COBRA or state continuation provision and the coverage under such provision was exhausted.
3. **Change in Employer Eligibility Rules or Employer Contributions.** The Participant's previous coverage was not under COBRA and either the coverage was terminated as a result of loss of eligibility for coverage, coverage was terminated for a class of similarly situated individuals, or employer contributions toward such coverage were terminated.
4. **A Move out of the Plan's Service Area.** The Participant's previous coverage was terminated because the Participant no longer resides, lives or works in the Plan's Service Area and the Plan does not provide coverage for that reason.
5. **Cessation of Dependent status.** The Participant attains an age in excess of the maximum age for coverage of a Dependent Child.
6. **Reaching the Lifetime Maximum.** The Eligible Employee or Eligible Dependent's coverage was exhausted by reaching a lifetime limit on all benefits.

Requests for Special Enrollment must be received by The Plan not later than *thirty (30)* days after the date of exhaustion or termination of coverage.

State Children's Health Insurance Program (SCHIP) Reauthorization Act of 2009

The State Children's Health Insurance Program (SCHIP) Reauthorization Act of 2009 grants Special Enrollment Rights to Medicaid and SCHIP eligible individuals when any of the following conditions are met:

1. An Eligible Group Member or Eligible Dependent(s) lose coverage under a Medicaid or a SCHIP program due to loss in eligibility. Requests for special enrollment must be received by The Plan no later than *sixty (60)* days after the date of termination of Medicaid or SCHIP coverage.

2. An Eligible Group Member or Eligible Dependent(s) become eligible for state premium assistance under a Medicaid or a SCHIP program. Requests for special enrollment must be received by The Plan no later than *sixty (60)* days after the date of eligibility for state premium assistance is determined.

In order to special enroll an Eligible Employee's new Dependent, The Plan will require the Eligible Employee to be enrolled also. Special enrollment rights extend to all benefit packages available under The Plan.

AMENDMENT #2	Section 10. Options After Coverage Is Ended

The provision titled ***How much does COBRA continuation coverage*** *cost is amended to include the following paragraph.*

5. How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension to continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated Plan participant or ~~f~~ beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in the COBRA Notification Letter.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282 for more information about these new tax provisions.

The American Recovery and Reinvestment Act of 2009 gives "Assistance Eligible Individuals" the right to pay reduced COBRA premiums for periods of coverage beginning on or after February 17, 2009 and can last up to 9 months. To be considered an "Assistance Eligible Individual" and get reduced premiums you:

a. MUST be eligible for continuation coverage at any time during the period from September 1, 2008 through December 31, 2009 and elect the coverage;
b. MUST have a continuation coverage election opportunity related to an involuntary termination of employment that occurred at some time from September 1, 2008 through December 31, 2009;
c. MUST NOT be eligible for Medicare; AND
d. MUST NOT be eligible for coverage under any other group health plan, such as a plan sponsored by a successor employer or a spouse's employer.

Individuals who experienced a qualifying event as the result of an involuntary termination of employment at any time from September 1, 2008 through February 16, 2009 and were offered, but did not elect, continuation coverage OR who elected continuation coverage and subsequently discontinued it may have the right to an additional 60-day election period.

If, after you elect COBRA and while you are paying the reduced premium, you become eligible for other group health plan coverage or Medicare you MUST notify the plan in writing. If you do not, you may be subject to a tax penalty.

Electing the premium reduction disqualifies you for the Health Coverage Tax Credit. If you are eligible for the Health Coverage Tax Credit, which could be more valuable than the premium reduction, you will have received a notification from the IRS.

The amount of the premium reduction is recaptured for certain high income individuals. If the amount you earn for the year is more than $125,000 (or $250,000 for married couples filing a joint federal income tax return) all or part of the premium reduction may be recaptured by an increase in your income tax liability for the year. If you think that your income may exceed the amounts above, you may wish to consider waiving your right to the premium reduction. For more information, consult your tax preparer or visit the IRS webpage on The American Recovery and Reinvestment Act of 2009 at www.irs.gov.

For general information regarding your plan's COBRA coverage or for specific information related to The Plan's administration of The American Recovery and Reinvestment Act of 2009 Premium Reduction or to notify the plan of your ineligibility to continue paying reduced premiums, contact Member Services toll free at 1-800-752-5863 or (605) 328-6800.

If you are denied treatment as an "Assistance Eligible Individual" you may have the right to have the denial reviewed. For more information regarding reviews or for general information about the The American Recovery and Reinvestment Act of 2009 Premium Reduction go to www.dol.gov/COBRA or call 1-866-444-EBSA (3272).

All other terms and provisions of your benefits policy, including any amendments we may have previously issued, remain unaltered and in effect.

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Amendment to Your South Dakota Large & Small Group Health Benefits Policy

This Amendment is effective February 1, 2008 and applies to your health Certificate of Coverage dated January 2006. Please review this document carefully and keep it with your Policy for future reference.

AMENDMENT #1 | Entire document

All references to "Certificate of Coverage" is hereby deleted and replaced by "Policy."

All reference to "Health Services Department" is hereby deleted and replaced by "Utilization Management Department."

All reference to "Medical Management Quality Committee" is hereby deleted and replaced by "Physician Quality Committee."

AMENDMENT #2 | Introduction: Member Rights

Provision #7 is hereby deleted and replaced by the following:

7. Members have the right to a candid discussion with the Practitioners and/or Providers responsible for coordinating appropriate or medically necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with Practitioners and/or Providers in decision making regarding their treatment plan.

AMENDMENT #3 | Introduction: Service Area

The provision titled, ***Service Area****, for IOWA* is amended to include Ida County.

AMENDMENT #4 | Section 1: Enrollment. Eligibility Requirements for Dependents.

The provision defining a dependent child is hereby deleted and replaced with the following:

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

1. Be unmarried;
2. Receive more than half of his or her support from the Subscriber; and
3. Be one of the following:
   a. age eighteen (18) or younger; or
   b. age twenty-nine (29) or younger 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 when the child was age eighteen (18) (or twenty-nine (29), 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.

AMENDMENT #5 | Section 1: Special Enrollment for Individuals Losing Other Coverage

This provision is hereby deleted and replaced with the following:

Special Enrollment Rights

Special enrollment rights apply when an individual becomes an Employee's Dependent through marriage, birth, adoption, or placement for adoption, and also when an Employee's Dependent loses health coverage. In order to special enroll an Eligible Employee's new Dependent, The Plan will require the Eligible Employee to be enrolled also. Special enrollment rights extend to all benefit packages available under The Plan. Special enrollees are not treated as Late Enrollees subject to the pre-existing waiting period.

Any Eligible Group Member or Eligible Dependent who was not previously enrolled in the Plan and has lost prior coverage shall be able to enroll in the Plan within *thirty (30)* days after the date of exhaustion of the previous coverage provided that the following conditions are met:

1. **Waived Coverage.** The Eligible Group Member or Eligible Dependent was covered under a Group health plan or had health insurance coverage at the time coverage was initially (upon date of hire) offered to the Eligible Group Member or Eligible Dependent; or, after subsequently enrolling in other coverage, the Eligible Employee had an opportunity to enroll during the open enrollment period or at the time of a special enrollment period, but again chose not to enroll; and the Eligible Group Member stated

in writing at such time that coverage under a Group health plan or health insurance coverage was the reason for declining enrollment (applicable only if the Group required such a statement at such time and provided the individual with notice of such requirement at such time).

2. **Exhausted COBRA.** The Eligible Group Member's or Eligible Dependent's previous coverage was under a COBRA or state continuation provision and the coverage under such provision was exhausted.
3. **Change in Employer Eligibility Rules or Employer Contributions.** The Participant's previous coverage was not under COBRA and either the coverage was terminated as a result of loss of eligibility for coverage, coverage was terminated for a class of similarly situated individuals, or employer contributions toward such coverage were terminated.
4. **A Move out of the Plan's Service Area.** The Participant's previous coverage was terminated because the Participant no longer resides, lives or works in the Plan's Service Area and the Plan does not provide coverage for that reason.
5. **Cessation of Dependent status.** The Participant attains an age in excess of the maximum age for coverage of a Dependent Child.
6. **Reaching the Lifetime Maximum.** The Eligible Employee or Eligible Dependent's coverage was exhausted by reaching a lifetime limit on all benefits.

Requests for Special Enrollment must be received by The Plan not later than *thirty (30)* days after the date of exhaustion or termination of coverage.

AMENDMENT #6	Section 2. How you get care. Identification Cards.

*The first paragraph in the provision for **Identification Cards** is hereby deleted and replaced with the following:*

The Plan will send you an identification (ID) card when you enroll. You must show it whenever you receive services from a Provider, a healthcare facility, or fill a prescription at a Plan pharmacy. If you fail to show your ID card at the time you receive healthcare services or prescription drugs, you will be responsible for payment of the claim after the Participating Practitioner's and/or Provider's timely filing period of one-hundred-twenty (120) days has expired. Your coverage will be terminated if you use your ID card fraudulently or allow another individual to use your ID card to obtain services.

AMENDMENT #7	Section 2. How you get care. Preconditions for Coverage.

*The third paragraph provision regarding **Emergency and Urgent Care Situations** is hereby deleted and replaced with the following:*

If during an Emergency care or urgent care situation, the Member is in the Service Area and is alert, oriented and able to communicate (as documented in medical records); the Member must direct the ambulance to the nearest Participating Provider.

AMENDMENT #8	Section 2. How you get care. Utilization Review Process.

The following provision revises the description of how to access the Utilization Review department by adding the Plan's fax number.

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. You can also fax the Plan at (605) 328-6813.

AMENDMENT #9	Section 2. How you get care. Utilization Review Process.

The following provision is added as the fifth paragraph to the section on **Prospective (pre-service) Review of Services (Certification/Prior Authorization):**

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

AMENDMENT #10	Section 2. How you get care. Services that Require Prospective Review/Prior Authorization (Certification)

This provision is added to the list of services that require prior authorization:

- Intensive Outpatient Programs for substance abuse treatment

The provision on Referrals is hereby deleted and replaced by the following:

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 Reduced Payment 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.

AMENDMENT #11	Section 2. How you get care. Prospective Review Process (Non-urgent Pre-service) for Elective Inpatient Hospitalizations, Non-Urgent Medical and Behavioral Health Care, Pharmaceutical and Benefit Requests

The third paragraph provision regarding obtaining authorization (Certification) for services is hereby deleted and replaced with the following:

You are ultimately responsible for obtaining authorization (Certification) from the Utilization Management Department. Failure to obtain Certification will result in coverage at the Reduced Payment Level.

AMENDMENT #12	Section 2. How you get care. Prospective Review Process (Non-urgent Pre-service) for Elective Inpatient Hospitalizations, Non-Urgent Medical and Behavioral Health Care, Pharmaceutical and Benefit Requests

*The third paragraph provision in the section titled **Concurrent Review Process for Medical and Behavioral Health Care Requests,** is hereby deleted and replaced with the following:*

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 an urgent concurrent 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.

AMENDMENT #13	Section 2. How you get care. Prospective Review Process (Non-urgent Pre-service) for Elective Inpatient Hospitalizations, Non-Urgent Medical and Behavioral Health Care, Pharmaceutical and Benefit Requests

*The title of the 5th paragraph provision in the section titled **Concurrent Review Process for Medical and Behavioral Health Care Requests,** is changed to:*

Urgent Concurrent Reviews Requested After Twenty-Four (24) Hours Prior to Expiration of Authorization

AMENDMENT #14	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers

This provision describing preventive care that is covered for adults is hereby deleted and replaced with the following:

Preventive care, adult
FOR MEN ONLY

Prostate Screening

- One prostate cancer screening including PSA every year:
  - Ages 50 and older; or
  - Ages 40 and older who are symptomatic or in a high risk category

AMENDMENT #15	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers

These provisions describing preventive care that is covered for children are hereby deleted and replaced with the following:

Preventive care, children
Pediatric Preventive visits including periodic examinations and laboratory testing, as outlined in the Plan Preventive Health Guidelines. 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.

Routine Immunizations
Medically accepted methods of prophylaxis which prevent disease

AMENDMENT #16	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers

These provisions describing covered maternity benefits are hereby deleted and replaced with the following:

Maternity Care

NOTE: Due to the inability to predict admission; you or your Practitioner and/or Provider must notify the Plan of your expected due date when the pregnancy is confirmed. You must also notify the Plan of the date of scheduled C-sections when it is confirmed.

Maternity care includes prenatal through postnatal maternity care and delivery and care for complication of pregnancy of mother. We cover up to two (2) routine ultrasounds per pregnancy to determine fetal age, size, and development.

The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of *forty-eight (48)* hours for a vaginal delivery to a minimum of *ninety-six (96)* hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Practitioner and/or Provider, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If such an inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by Participating Practitioners and/or Providers competent in postpartum care and newborn assessments.

NOTE: We encourage you to participate in our Healthy Pregnancy Program; Call 1-800-805-7938 to enroll.

AMENDMENT #17	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers

These provisions describing covered and non-covered family planning benefits are hereby deleted and replaced with the following:

Covered Family Planning Benefits

- Family Planning Services include consultations, and pre-pregnancy planning
- There is no coverage for oral contraception unless required by State law and/or covered by a supplemental prescription drug rider as purchased by your Employer (Note: See the prescription drug benefit in Section 3(e))
- Voluntary Sterilizations include tubal ligations and vasectomies
- Mirena IUD device is covered up to $350 every five (5) years

Not covered:

- genetic counseling or testing
- reproductive Health Care Services prohibited by the laws of This State
- elective abortion services
- birth control drugs and devices including but not limited to the Implanon and implantable contraceptive device
- diaphragms, condoms, foam or sponges
- sterilization of Dependent children
- reversal of voluntary sterilization

AMENDMENT #18	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers

This provision is removed from list of diabetic services and supplies that are not covered and is now a covered service:

Diabetes supplies, equipment, and education

- dialysis services received by non-Participating Providers when traveling out of the Service Area

This provision is added to the list of diabetic services and supplies that are not covered:

Not covered: continuous glucose monitoring system

AMENDMENT #19	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers

This provision is added to the list of services that are not covered:

Physical, cardiac, speech and occupational therapies

- Speech therapy 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.

AMENDMENT #20	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers

The following DME has been removed from the list of equipment that requires Certification/prior authorization:

Durable Medical Equipment (DME)

- oxygen concentrators

AMENDMENT #21	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers

These provisions describing covered tobacco cessation benefits are hereby deleted and replaced with the following:

Tobacco/Smoking Cessation Treatment
Non-drug 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.

The following smoking deterrent medications will be covered with confirmation of smoking abstinence after a 6-month period: nicotine patches, gum, nasal spray, Chantix, Zyban or Wellbutrin.

AMENDMENT #22	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers

This provision describing non-coverage for surgeries to correct congenital deformities is clarified to read:

Reconstructive Surgery
Not covered: Surgeries to correct congenital deformities unless treatment was started before the age of eight (8).

AMENDMENT #23	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers

The following provision applies to the covered section and deletes the requirement that members be covered under the Health Plan during the time of illness or injury to the teeth in order for oral surgical procedures to be covered and adds coverage as follows:

Oral and maxillofacial surgery
Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth
Orthoganathic Surgery per Plan guidelines

The following provision is added to the non-covered section:
Not covered: Extraction of Wisdom teeth

AMENDMENT #24	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers

These provisions describing covered transplant benefits are hereby deleted and replaced with the following:

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 and are performed at Plan Participating Centers of Excellence for the following conditions are covered:

Solid organ transplants are limited to:

- Cornea
- Heart
- Heart/lung
- Kidney

- Kidney/pancreas
- Liver
- Intestinal transplants
  - Small intestine
  - Small intestine with the liver
  - Small intestine with multiple organs, such as the liver, stomach, and pancreas
- Lung: single, double
- Pancreas

Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description.)

- Allogenic transplants for:
  - Acute or chronic lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia
  - Burkitt's lymphoma for adolescents and young adults
  - Advanced Hodgkin's lymphoma
  - Advanced non-Hodgkin's lymphoma
  - Chronic myelogenous leukemia
  - Severe combined immunodeficiency
  - Severe or very severe aplastic anemia

- Autologous transplant for:
  - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia
  - Advanced Hodgkin's lymphoma
  - Advanced non-Hodgkin's lymphoma
  - Advanced neuroblastoma
  - Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)

- Blood or marrow stem cell transplants for:
  - Allogenic transplants for
  - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)
  - Advanced forms of myelodysplastic syndromes
  - Sickle cell anemia

Blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for:

- Allogenic transplants for:
  - Multiple myeloma

- Nonmyeloablative allogenic transplants for:
  - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia
  - Advanced forms of myelodysplastic syndromes
  - Advanced Hodgkin's lymphoma
  - Advanced non-Hodgkin's lymphoma
  - Chronic myelogenous leukemia

- Autologous transplants for:
  - Chronic myelogenous leukemia
  - National Transplant Program

All transplants must be provided at Plan participating Center of Excellence facilities

Prescribed post-transplant immunosuppressant outpatient drugs required as a result of a covered transplant

Coverage includes up to $25,000 for acquisition fees

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*

AMENDMENT #25	Section 3(c) Emergency services/accidents

The definition of an "urgent care situation" is hereby deleted and replaced with the following:

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. 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:

- 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
- 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.

The Health Plan covers worldwide 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.

AMENDMENT #26	Section 3(c) Emergency services/accidents

The third paragraph provision regarding emergencies that occur within the service area is revised by adding the following statement:

Emergency within our service area
The Health Plan covers emergency services necessary to screen and stabilize members without pre-certification in cases where a prudent layperson, acting reasonably, believed that an emergency medical condition existed.

AMENDMENT #27	Section 3(d) Mental health and substance abuse benefits

The following provision is added after the second paragraph to the covered benefits section for mental health benefits:

Mental health benefits (biologically-based)

If you are having difficulty obtaining an appointment with a mental health practitioner and/or Provider or for behavioral health needs assessment services by phone, call the Sanford USD Medical Center Triage Line at (605) 328-4777 or toll free at (888) 996-4673.

This provision is added to the list of mental health services that are covered:

Partial Hospital Programs and Day Treatments

These provisions describing covered addiction and substance abuse benefits are hereby deleted and replaced with the following:
Addiction and substance abuse benefits

Addiction substance abuse 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 and Partial Hospital Program/Day Treatment

Every *two (2)* days of Intensive Outpatient Programs and 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 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 Intensive Outpatient Programs, Partial Hospital Programs/Day Treatment

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.

AMENDMENT #28	Section 3(e) Prescription drug benefits

These provisions revises the following non-covered benefits:

Not covered:

- Acne medication for Members over age thirty (30)
- Birth control drugs and devices including but not limited the Implanon and other implantable contraceptive devices

AMENDMENT #29	Section 3(f) Dental benefits

The following provision applies to the covered section and deletes the requirement that members be covered under the Health Plan during the time of illness or injury to the teeth in order for oral surgical procedures to be covered and adds coverage as follows:

Dental benefits
Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth

The following provision is added to the non-covered section:

Not covered: Extraction of Wisdom teeth

AMENDMENT #30	Section 4. Limited and Non-Covered Services

This provision hereby deletes and replaces exclusion #26:

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.

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; 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

These provisions are added as non-covered services:

- Inpatient or residential treatment of bulimia, anorexia or other eating disorders\
- Genetic testing

AMENDMENT #31	Section 5. How services are paid for by the Plan

This provision revises the first paragraph to clarify that Members must present their ID cards when receiving healthcare services:

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 must present your current identification card and pay your Copay.

This provision revises the first paragraph to clarify that Members may need to file their own claims when receiving healthcare services from Non-Participating Providers:

Reimbursement of Charges by Non-Participating Providers
You may need to file a claim when you receive services from Non-Participating Practitioner and/or Providers. Sometimes these Practitioners and/or Providers submit a claim to us directly.

AMENDMENT #32	Section 6. Problem Resolution

The first paragraph of this provision is revised by adding the following statement:

MEMBER GRIEVANCE PROCEDURES
The Member or his/her legal guardian may designate in writing to Sanford Health Plan an authorized representative to act on his/her behalf. This written designation of representation from the Member should accompany the request.

The definition of an "urgent care request" is hereby deleted and replaced with the following:
Definitions
Urgent care situation: A degree of illness or injury which is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours. Urgent care requests means a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination could:

a. 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
b. 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.

AMENDMENT #33	Section 6. Problem Resolution

*This provision under the section titled, **Types of Grievances (Appeals), Filing Deadline,** is revised to clarify that Authorized Member Representatives must be designated in writing by the Member.*

> 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 (as designated in writing by the Member), the Member or their Authorized Representative may file a Grievance with the Plan requesting a first level review of the Adverse Determination.

*This provision under the section titled, **1st Level Standard Review Procedure for Complaints (Grievances NOT involving Adverse Determination,)** is revised to clarify that Authorized Member Representatives must be designated in writing by the Member.*

> A standard appeal may be requested by a Member, his or her representative (as designated in writing) 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.

*This provision under the section titled, **Grievance Procedure involving Adverse Determinations,** is revised to clarify that Authorized Member Representatives must be designated in writing by the Member.*

> If the Member or a Member's authorized representative (as designated in writing) 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.

AMENDMENT #34	Section 6. Problem Resolution

Provision #3 under the section titled, ***Independent, External Review of Final Determinations****, is revised by adding the following statements:*

Independent, External Review of Final Determinations

3. Conduct of the appeal program as follows:

   iv. Engages adequate numbers of actively participating practitioners with the appropriate level and type of clinical knowledge and experience to adjudicate appeals;
   v. Bases its review on sound clinical evidence, referencing peer-review literature, medical technology assessments and the individual patient record;
   vi. Carefully protects member identify, medical record and case information from any unnecessary disclosure; and
   vii. Have effective systems in place to manage the many administrative aspects of appeals, such as tracking cases and accessing legal and medical documents. Provides staff with education and skills training that is required to produce sound, high-quality results.

AMENDMENT #35	Section 7. Coordination of Benefits

Provision #1 under the section "Order of Benefit Determination Rules" is hereby deleted and replaced by the following:

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 under South Dakota State law §§ 58-18A-53 to 58-18A-83, inclusive, 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 this law;
d. If a person is covered by more than one secondary plan, this order of benefit determination provisions 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. Except as provided in subdivision (b) of this section, a plan that does not contain order of benefit determination provisions that are consistent with South Dakota State law §§ 58-18A-53 to 58-18A-83, inclusive, is always the primary plan unless the provisions of both plans, regardless of the provisions of this section, state that the complying plan is primary;
f. Coverage that is obtained by virtue of membership in a group and 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 contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

AMENDMENT #36	Section 8. Definitions

The following definitions are hereby deleted and replaced with the following:

Coinsurance	The percentage of charges to be paid by a Member for Covered Services after the Deductible has been met.
Concurrent Review	Concurrent Review is Utilization Review for an extension of previously approved, ongoing course of treatment over a period of time or number of treatments typically associated with inpatient care, residential behavioral care, intensive outpatient behavioral care and ongoing ambulatory care.
Out-of-Network Benefit Level	The lower level of benefits provided by The Plan, as defined in the attached Summary of Plan Benefits, when a Member seeks services from a Non-Participating Provider.
Partial Hospitalization Program	Also known as day treatment or partial hospitalization programs 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.

The term is added to the definitions section:

Reduced Payment Level	The lower level of benefits provided by The Plan, as defined in the attached Summary of Plan Benefits, when a Member seeks services from a Participating or Non-Participating Provider without Plan certification or prior-authorization when certification/prior-authorization is required.

AMENDMENT #37	Section 10. Options After Coverage is Ended

The third paragraph under the COBRA Section #1 is revised as follows:

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

1. What is Continuation Coverage?

It is the Member's responsibility to notify Sanford Health Plan or their employer of a divorce, legal separation, or a child ceasing to be a dependent under the terms of the Plan within sixty (60) days of the date of the event.

All other terms and provisions of your benefits policy, including any amendments we may have previously issued, remain unaltered and in effect.

Notice of Privacy Practices

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

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

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

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

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

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

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

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

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

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

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

Other Health-Related Products or Services. We may, from time to time, use your personal health information to determine whether you might be interested in or benefit from treatment alternatives or other health-related programs, products or services which may be available to you as a Member of the health plan. For example, we may use your personal health information to identify whether you have a particular illness, and contact you to advise you that a disease

management program to help you manage your illness better is available to you as a health plan Member. We will not use your information to communicate with you about products or services which are not health-related without your written permission.

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

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

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

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

RIGHTS THAT YOU HAVE

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

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

Accounting for Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us of your personal health information after April 14, 2003. Requests must be made in writing and

signed by you or your representative. Accounting request forms are available from Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110.

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

Complaints. If you believe your privacy rights have been violated, you can file a written complaint with Sanford Health Plan, Member Services Department, PO Box 91110, Sioux Falls, SD 57109-1110 or you can file a verbal complaint by calling Sanford Health Plan, Member Services Department at (605) 328-6800 or toll free at 1-800-752-5863.You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within *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 Employer/and or 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 their employer of any changes of eligibility that may affect their membership or access to services. The employer is responsible for notifying the Plan.

Service Area

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

The Service Area for IOWA includes the following counties:

CLAY	EMMET	O'BRIEN	SIOUX
DICKINSON	LYON	OSCEOLA	PLYMOUTH

The Service Area for MINNESOTA includes the following counties:

COTTONWOOD	LYON	PIPESTONE	YELLOW MEDICINE
JACKSON	MARTIN	REDWOOD	
LAC QUI PARLE	MURRAY	ROCK	
LINCOLN	NOBLES	WATONWAN	

Medical Terminology

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

Section 1. Enrollment

When to Enroll

To become a Subscriber, an Eligible Group Member must submit an enrollment application within the applicable Initial Enrollment Period or any Open Enrollment Period. The Initial Enrollment Period starts on the day the Group Member first becomes an Eligible Group Member, and ends *thirty (30)* days later. Open Enrollment is a period of time at least once a year when Eligible Group Members may enroll themselves and their Eligible Dependents in the Plan.

A "Late Member" is an Eligible Group Member or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage. Contact your employer to determine if "Late Members" may enroll at any time during the year or only during the Open Enrollment. A Member is not a "Late Member" if a special enrollment period, as described below, allows the Member to enroll:

No Eligible Group Member will be considered a "Late Member" if one of the following apply:

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

How to Enroll

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

The Group must:

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

The Group Member must:

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

When Coverage Begins

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

If all the requirements for coverage are not met immediately, the effective date of coverage may be delayed. However, this delay may not exceed *thirty (30)* days from the date that all coverage requirements are met.

Health Care Services that are covered under an extension of benefits from a previous Group health plan or other coverage arrangement will not be covered under this Contract until the extension under the prior plan ends.

Eligibility Requirements for Dependents

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

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

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

1. Be unmarried;
2. Receive more than half of his or her support from the Subscriber; and
3. Be one of the following:
   a. under nineteen (19) years old; or
   b. under twenty-five (25) years old and enrolled in and attending an accredited college, university, or trade or secondary school on a full-time basis. For the purpose of the Plan, the school's definition of "full-time student" shall be used to determine if a Dependent is a full time student.; or
   c. incapable of self-sustaining employment and Dependent on her or his parents or other care Providers for lifetime care and supervision because of a disabling condition that was present before the child was nineteen (19) (or twenty-five (25), if a full-time student). If the Plan so requests, the Subscriber must provide proof of the child's disability within *thirty-one (31)* days of the Plan's request.

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

1. Provide necessary information to the custodial parent in order for the Dependent Child to receive benefits under The 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;
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; or
3. The Group has eliminated family coverage for all of its Members.

When and How to Enroll Dependents

When to Enroll Dependents

A Subscriber shall apply for coverage for a Dependent during the same periods of time that the Subscriber may apply for his or her own coverage. However, there is an exception for newborn and adopted children; see "Coverage from Birth" and "*Children Placed for Adoption*" section below. There is also an exception for Spouses; see "*New Spouses*" section below.

How to Enroll Dependents

A Subscriber must:

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

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.

3. Coverage from Birth

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

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

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

4. Adoption or Children Placed for Adoption

If a Subscriber, 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 Service Charge payments are made.

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

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

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

5. New Spouses and Dependent Children

If a Subscriber 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 will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for the Spouse and/or the Dependent within *thirty-one (31)* days of the date of marriage and the required Service Charge payments are made.

In the case of a Group Member who is eligible to be enrolled in the Plan, but failed to enroll during a previous enrollment period, gets married, the Group Member and his or her Spouse and any of the Spouse's Dependents who become Eligible Dependents of the Group Member as a result of the marriage will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for within *thirty-one (31)* days of the date of marriage and the required Service Charge payments are made.

Special Enrollment for Individuals Losing Other Coverage

Any Eligible Group Member or Eligible Dependent of an Eligible Group Member who was not previously enrolled in the Plan and has lost prior coverage shall be able to enroll in the Plan within *thirty (30)* days after the date of exhaustion of the previous coverage provided that the following conditions are met:

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

Section 2. 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 3) 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 attached Summary of Plan Benefits and Summary of Pharmacy Benefits.

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 3 (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* 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 health services 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 8. A Physician, with knowledge of the Member's medical condition, who determines a request to be "urgent" as defined in Section 8 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 3 (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. NOTE: For employer groups who purchase Plans with no out-of-network coverage, benefits are not payable when you fail to obtain certification.

The Utilization 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 6 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 6 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 6 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 6 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.
8. 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 3(a) Medical services and supplies provided by Physicians and other health care professionals

IMPORTANT	**Here are some important things you should keep in mind about these benefits:** 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.)	IMPORTANT

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:	Pathology	CT Scans/MRI
Blood tests	X-rays	Ultrasound
Urinalysis	PET Scans – NOTE: PET Scans require Certification	Electrocardiogram (EKG)
Non-routine pap tests	DEXA Scans	Electroencephalography (EEG)
Non-routine PSA tests	Non-routine mammograms	

Preventive care, adult

As outlined in the Plan Preventive Health Guidelines

Periodic preventive physical examinations including period diagnostic procedures, 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

Preventive care, children

As outlined in the Plan Preventive Health Guidelines

Pediatric Preventive visits including periodic examinations, laboratory testing, diagnostic imaging 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.

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

Maternity care

NOTE: Due to the inability to predict admission; you or your Physician must notify the Plan of your expected due date when the pregnancy is confirmed. You must also notify the Plan of the date of scheduled C-sections when it is confirmed.

Maternity care includes prenatal through postnatal maternity care and delivery and care for complication of pregnancy of mother. We cover up to two (2) routine ultrasounds per pregnancy to determine fetal age, size, and development

The Plan shall not terminate inpatient benefits or require discharge of a mother or the newborn from the Hospital following delivery earlier than determined to be medically appropriate by the attending Physician after consultation with the mother and in accordance with the Guidelines for Perinatal Care, Third Edition, 1992, by the American Academy of Pediatrics and the American College of Obstetrics and Gynecologists.

The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of *forty-eight (48)* hours for a vaginal delivery to a minimum of *ninety-six (96)* hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Physician, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If such an inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by Participating Providers competent in postpartum care and newborn assessments.

NOTE: We encourage you to participate in our Healthy Pregnancy Program; Call 1-800-805-7938 to enroll.

Not covered: amniocentesis or chorionic villi sampling (CVS) solely for sex determination

Newborn Care

A newborn is eligible to be covered from birth. Member's must complete and sign the Plan's enrollment application form requesting coverage for the newborn within *thirty-one (31)* days of the infant's birth. For more information, see Section 1 on Enrollment and *When Dependent Coverage Begins.*

We cover care for the enrolled newborn child from the moment of birth including care and treatment for illness, injury, premature birth and medically diagnosed congenital defects and birth abnormalities (Please refer to "Reconstructive Surgery" in Section 3 (a) for coverage information of surgery to correct congenital defects).

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

Not covered: newborn delivery and nursery charges for adopted dependents prior to the adoption bonding period

Family planning

Family Planning Services include consultations, and pre-pregnancy planning

There is no coverage for contraception unless required by State law and/or covered by a supplemental prescription drug rider as purchased by your Employer (Note: See the as prescription drug benefit in Section 3(e))

Voluntary Sterilizations include tubal ligations and vasectomies

We cover voluntary sterilization performed secondary to a Cesarean section

Not covered:

- *genetic counseling or testing*
- *reproductive Health Care Services prohibited by the laws of This State*
- *elective abortion services*
- *birth control drugs and devices including but not limited to injectable contraceptive drugs (such as Depo provera), implantable contraceptive devices (such as IUDs or Norplant)*
- *diaphragms, condoms or sponges*
- *sterilization of Dependent children*
- *reversal of voluntary sterilization*

Infertility services

We cover testing for the diagnosis of infertility. Limited to Plan Guidelines.

Not covered:

- *treatment of infertility including artificial means of conception such as: artificial insemination, in-vitro fertilization, ovum or embryo placement or transfer, or gamete intra-fallopian tube transfer.*
- *cryogenic or other preservation techniques used in such or similar procedures;*
- *infertility medication;*
- *any other services or supplies related to artificial means of conception;*
- *reversals of prior sterilization procedures; and*
- *any expenses related to surrogate parenting*

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 7.

Not covered: 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*

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:

- 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 aphakic 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:

- *Vision exams (routine)*
- *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 3(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*

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.

The following smoking deterrent medications will be covered with confirmation of smoking abstinence after a 6-month period: nicotine patches, gum, nasal spray, Zyban or Wellbutrin.

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 3a). Deductible and coinsurance applies as outlined in your *Summary of Plan Benefits*.

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*
- *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 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:

- *Natural teach 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 vestivuloplasty*
- *Dental appliances of any sort, including but not limited to bridges, braces, and retainers, appliances for treatment of TMJ/TMD*

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 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), and peripheral Stem Cell Support (myeloablative or non-myeloablative) for:
   - Acute or chronic myelogenous leukemia;
   - Burkitt's lymphoma for adolescents and young adults;
   - Severe combined immunodeficiency disease;
   - Wiscott Aldrich syndrome;
   - Lysosomal storage disease;
   - Meyelodysplastic syndrome;
   - Aplastic anemia;
   - Non-relapsed or relapsed non-Hodgkin's lymphoma; 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;
   - Breast cancer stages II, III, IV;
   - Chronic myelogenous leukemia (CML);
   - Burkitt's lymphoma; and
   - Neuroblastomas
j. High dose chemotherapy with bone marrow transplantation for the approved treatment of solid tumors, such as cancer
k. Prescribed post-transplant immunosuppressant outpatient drugs required as a result of a covered transplant
l. Coverage includes up to $25,000 for acquisition fees
m. Medical expenses for the organ donor which are necessary for the transplant, and which are not covered by another Group health plan or other coverage arrangement

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 3(b) Services provided by a Hospital or other Facility

IMPORTANT

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

- 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.

IMPORTANT

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*

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)

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*

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 3(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 3(a)*, but only where the hospice retains responsibility for the care of the Member

Not covered: Independent nursing, homemaker services

Section 3(c) Emergency services/accidents

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

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 that would worsen the emergency, 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.

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*
- *Medical and Hospital costs resulting from a normal full-term delivery of a baby outside 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.

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*

Section 3(d) Mental health and substance abuse benefits

IMPORTANT

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

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.

IMPORTANT

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 substance abuse benefits

Addiction substance abuse 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*

Section 3(e) Prescription drug benefits

IMPORTANT

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

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.

IMPORTANT

- **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 you *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 1-800-805-793.

    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 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 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. Additionally, if there is no generic equivalent, you will still be required to pay the brand name Copay.

  *NOTE: For Members enrolled in a High Deductible Health Plan, the prescription drug benefit is subject to Plan deductible and coinsurance amounts.

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 Plans' Utilization Management Department, the member will be responsible for the full cost of the medication.

Diabetic drugs (See section 3(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 thirty-five (35)*
- *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*
- *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 drugs and devices including but not limited to injectable contraceptive drugs (such as Depo provera), implantable contraceptive devices (such as IUDs or Norplant)*

Section 3(f) Dental benefits

IMPORTANT

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

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 3 (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.

IMPORTANT

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:

- *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 vestivuloplasty.*
- *Dental appliances of any sort, including but not limited to bridges, braces, and retainers, appliances for treatment of TMJ/TMD*

Section 3(g) Out-of-Network benefits

IMPORTANT

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

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.)

NOTE: If your Summary of Plan Benefits includes excludes coverage for Out-of-Network Benefits, the *Out-of-Network Benefits Plan Amendment*, this Section is null and void per the Amendment.

IMPORTANT

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 Plan Benefits and Summary of Pharmacy Benefits.

All Out-of-Network services are subject to Reasonable Cost. As indicated in the Summary of Plan Benefits, for Out-of-Network Coverage, the Plan will pay a percentage of the Reasonable Cost after credit is given for payment of the applicable Copays, Deductibles, and Coinsurance, provided that the Plan determines that the billed charges are Reasonable. If the Plan determines that the billed charges are not reasonable, the Plan will only pay a percentage of the Reasonable Costs. Percentage amounts are indicated on the Summary of Plan Benefits.

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 3 above are covered with the following exceptions:

What is not covered Out of Network

- Services listed as "*not covered"* in Section 3;
- 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 4. 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 is 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

Pre-Existing Conditions

1. Health Care Services for Pre-Existing Conditions are excluded for a period of *one (1)* year *eighteen (18)* months for late Members following the effective date of coverage or the first day of a waiting period if one applies. The *one (1)* year period shall be reduced by the aggregate number of days that a Member was covered under Creditable Coverage.
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 the child as of the last day of the *thirty (30)* day period beginning with the date of birth, adoption or placement for adoption is covered under Creditable Coverage and that there has been no significant break in the Creditable Coverage.
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.
6. To obtain a Certificate of Creditable Coverage from Sanford Health Plan, call Member Services at (605) 328-6800 or toll free at 1-800-752-5863.

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 Plan Benefits 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.

Section 5. 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.

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 6. 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 8. A Physician, with knowledge of the Member's medical condition, who determines a request to be "urgent" within the meaning of subdivisions (1) and (2) in this paragraph shall be treated as an Urgent Care Request.

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 approved 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 8.

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 within *five (5)* working days after the date of receipt of the notice, the Plan will notify the Member in writing of their right to:

(a) Request the opportunity to appear in person before the review panel;
(b) Receive, upon request, copies of documents and records 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;
(e) Ask questions of the review panel; and
(f) Be assisted or represented by an individual of the Member's choice.

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 review meeting shall be held during regular office hours or at the Member's request, can be held via conference call. 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. 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.

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 rational; 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 7. Coordination of Benefits

If Member a 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 Group Member or the Group Member's covered Dependent has health care coverage under more than one Plan. "Plan" and "this Plan" are defined below.

If this COB provision applies, the order of benefit determination rules should be looked at first. Those rules determine whether the benefits of this Plan are determined before or after those of another plan. The benefits of this Plan:

1. shall not be reduced when, under the order of benefit determination rules, this Plan determines its benefits before another plan; but
2. may be reduced when, under the order of benefits determination rules, another plan determines its benefits first. The above reduction is described in the section below entitled: "*Effect of COB on the Benefits of this Plan*."

Definitions (for COB Purposes Only)

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

   Each contract or other arrangement for coverage under (a) or (b) is a separate plan. Also, if an arrangement has *two (2)* parts and COB rules apply only to one of the two, each of the parts is a separate plan.
2. "**This Plan**" refers to this certificate, which provides benefits for health care expenses.
3. "**Primary Plan/Secondary Plan**": The order of benefit determination rules state whether this Plan is a Primary Plan or Secondary Plan as to another plan covering the Member and covered Dependents.

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

   When this Plan is a Secondary Plan, its benefits are determined after those of the other plan and may be reduced because of the other plan's benefits.

   When there are more than *two (2)* plans covering the Member, this Plan may be a Primary Plan as to one or more other plans, and may be a Secondary Plan as to a different plan or plans.
4. "**Allowable Expense**" means a necessary, reasonable and customary health care service or expense including Deductibles, Coinsurance, or Copays, that is covered in full or in part by one or more plans covering the person for whom the claim is made. If a plan provides benefits in the form of services, the reasonable cash value of each service is considered an allowable expense and a benefit paid. An expense or service or a portion of an expense or service that is not covered by any of the plans is not an allowable expense. Expenses that are not allowable include the following:
   a. The difference between the cost of a private Hospital room
   and the cost of a semi-private Hospital 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 Reasonable Costs, any amount in excess of the highest of the Reasonable Costs 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 Reasonable Costs and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's payment arrangement shall be allowable expense for all plans; or

e. When benefits are reduced under a Primary Plan because a Member does not comply with The Plan provisions, the amount of such reduction will not be considered an allowable expense. Examples of such provisions are those related to second surgical opinions, 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. A plan that does not contain a COB provision that is consistent with this regulation is always primary. The exception is coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of The Plan provided by the contact holder. For example, major medical coverage that is superimposed over base plan Hospital and surgical benefits, and insurance type coverage that is written in connection with a closed panel plan to provide Out-of-Network benefits
   c. A plan may consider the benefits paid or provided by another plan in determining its benefits only when it is secondary to that other plan.

2. Rules. This Plan determines its order of benefits using the first of the following rules which applies:
   a. Non-Dependent/Dependent. The plan which covers the person as a Group Member, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the plan which covers the person as a Dependent. However, if the person is also a Medicare beneficiary, Medicare is:
      i. secondary to the Plan covering the person as a Dependent; and
      ii. primary to the Plan covering the person as other than a Dependent, for example a retired Group Member;
      then the order of benefits between the two plans is reversed so that the plan covering the person as a Group Member, Member, or Subscriber is secondary and the other plan is primary.

   b. Child Covered Under More Than One Plan. The order of benefits when a child is covered by more than one plan is:
      i. The primary plan is the plan of the parent whose birthday is earlier in the year if:
         - The parents are married;
         - The parents are not separated (whether or note they even have been married); or
         - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents longer is primary.

ii. If the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that 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.

iii. If the parents are not married, or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:

- The plan of the custodial parent;
- The plan of the Spouse of the custodial parent;
- The plan of the noncustodial parent; and then
- The plan of the Spouse of the noncustodial parent.

c. Active/Inactive Group Member. The benefit of a plan which covers a person as a Group Member who is neither laid off nor retired (or as that Group Member's Dependent) is primary. If the other plan does not have this rule, and if as a result, The Plans do not agree on the order of benefits, this rule is ignored. Coverage provided to an individual as a retired worker and as a Dependent of an actively working Spouse will be determined under Rule 2(a) above.

d. Continuation Coverage. If a person whose coverage is provided under a right of continuation pursuant to a federal or state law also is covered under another plan, the following shall be the order of benefit determination:

i) primary, the benefits of a plan covering the person as a Group Member, Member or Subscriber (or as that person's Dependent);

ii) secondary, the benefits under the continuation coverage. If none of the above rules determines the order of benefits, the benefits of the plan which covered a Group Member, Member or Subscriber longer is primary.

e. If the preceding rules do not determine the primary plan, the allowable expenses shall be shared equally between the plans meeting the definition of plan under this regulation. In addition, this plan will not pay more than it would have paid had it been primary.

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, this Plan is a Secondary Plan as to one or more other plans. In that event the benefits of this Plan may be reduced under this section. Such other plan or plans are referred to as "the other plans" in paragraph "b(ii)" immediately below.

2. Reduction in this Plan's Benefits. The benefits of this Plan will be reduced when the sum of:

i. the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and

ii. the benefits that would be payable for the Allowable Expenses under the other plans, in the absence of provisions with a purpose like that of this COB provision, whether or not claim is made, exceeds those Allowable Expenses in a Claim Determination Period. In that case, the benefits of this Plan will be reduced so that they and the benefits payable under the other plans do not total more than 100% of those Allowable Expenses.

iii. 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.

When the benefits of this Plan are reduced as described above, each benefit is reduced in proportion. It is then charged against any applicable benefit limit of this Plan.

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 person. The Plan need not tell, or get the consent of any person to do this. Each person claiming benefits under this Plan must give the Plan any facts it needs to pay the claim.

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 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 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 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 8. Definitions of terms we use in this brochure

Ambulatory Surgical Center	A lawfully operated, public or private establishment that: a. Has an organized staff of Providers; b. Have 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. Do 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.
Calendar Year	A period of one year which starts on January 1st and ends December 31st.
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.
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 all attachments, the Group's application, the applications of the Subscribers and the Health Maintenance Contract.
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: a. Medicare or Medicaid; b. An employer-based health insurance plan or health benefit arrangement that provides benefits similar to or exceeding benefits provided under a health benefit plan; c. An individual health insurance policy; d. Chapter 55 of Title 10, United States Code; e. A medical care program of the Indian Health Service or of a tribal organization; f. A state health benefits risk pool; g. A health plan offered under Chapter 89 of Title 5, United States Code; h. A public health plan; i. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504)(e)); j. College plan; or k. 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.
Dependent	The Spouse and any Dependent Child of a Subscriber.
Dependent Child	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 Group Member	Any Group Member who meets the specific eligibility requirements of the Group's 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: 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 have 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.
[The] Group	The entity that sponsors this health maintenance agreement as permitted by SDCL-58-41 under which the Group Member is eligible and applied for this Contract.
Group Member	Any employee, sole proprietor, partner, director, officer or Member of the Group.
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.
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: 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.
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.
Open Enrollment	A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan.
Out-of-Network Benefit Level	The lower level of benefits provided by The Plan, as defined in the attached Summary of Plan Benefits, when a Member seeks services from a Non-Participating Provider without Plan Certification.

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, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received during the six month Period ending on the enrollment date. The enrollment date is the first day of coverage or first day of the waiting period. Pregnancy and genetic information in the absence of a condition related to such information are not considered Pre-Existing Conditions.
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.
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.
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.
Service Charge	The amount paid by the Group to the Plan on a monthly basis for coverage for Members under this Contract.
Spouse	An individual who is a Subscriber's current lawful Spouse under the laws of This State.
Subscriber	An Eligible Group 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.
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.
Us/We	Refers to Sanford Health Plan

Section 9. How coverage ends

Termination by the Subscriber

Upon a qualifying event, you may be allowed to terminate coverage for you and/or any Dependent(s) at any time. The Plan must receive a written request from the Group to end coverage. The Subscriber will be responsible for any Service Charges through the date of termination or the end of the calendar month in which termination occurs, whichever is later.

Termination of Member Coverage

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

1. **Service Charge Payments**. Failure to make any required Service Charge payments when due. A grace period of *thirty-one (31)* days, following the due date will be allowed for the payment of any Service Charge after the first fee is paid. During this time, coverage will remain in force. If the Service Charge is not paid on or before the end of the grace period, coverage will terminate at the end of the grace period.
2. **Employee Termination.** The last day of the month in which date the Member's active employment with the Group is terminated is the date benefits will cease for the Member(s).
3. **Contract Termination**. This contract terminates.
4. **Eligibility**. The last day of the month in which the Member is no longer eligible for coverage under This Contract.
5. **Retiree Termination.** The last day of the month in which the retiree or his or her Dependents become eligible for Medicare.
6. **Death.** The date the Member dies.
7. **Lifetime Maximum.** When lifetime maximum benefits of The Plan have been met.
8. **Armed Forces.** The first of the month following the date the Member enters the armed forces of any country as a full-time Member.
9. **Fraudulent Information**. The enrollment date a Member's application form contains fraudulent information.
10. **Use of ID Card by Another**. The date a Member allows another individual to use his or her ID card to obtain services.

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

Member Appeal of Termination

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

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

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

Notice of Group Termination of Coverage

Termination due to Non-Renewal

The Group will give *thirty (30)* days written notice of the termination to the Members. For purposes of This Contract, "give written notice" means to present the notice to the Member or mail it to the Member's last known address.

This notice will set forth at least the following:

1. The effective date and hour of termination or of the decision to not renew coverage;
2. The reason(s) for the termination or nonrenewal; and
3. The Member's options listed below, including requirements for qualification and how to exercise the Member's rights:
   a. the availability of Continuation of Coverage, if any; and
   b. the fact that the Member may have rights under federal COBRA provisions, independent from any provisions of This Contract, and should contact the Group for information on the COBRA provisions.

Termination due to Non-Payment of Premiums

If an employer fails to submit premium payment to The Plan resulting in loss of coverage to the Members, switches plans or cancels the coverage, The Group is required to give written notice of the termination to the Members as soon as reasonably possible but no later than *ten (10)* days after the date of termination.

Section 10. Options After Coverage is Ended

Federal Continuation of Coverage Provisions ("COBRA")

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

1. What is Continuation Coverage?

Federal law requires that health plans give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered the group health plan, the covered employee's spouse, and the dependent children of the covered employee.

Qualifying Events include:

a. Termination of a covered employee's employment (other than for gross misconduct);

b. Reduction in hours of a covered employee's employment;

c. Death of a covered employee;

d. Divorce or legal separation of a covered employee;

e. A covered dependent child's ceasing to qualify as a "dependent child" under the terms of this Plan;

f. A covered employee's entitlement to Medicare; and

g. An employer's commencement of a bankruptcy proceedings.

It is the Member's responsibility to notify Sanford Health Plan of a divorce, legal separation, or a child ceasing to be a dependent under the terms of the Plan.

Continuation of coverage is the same coverage that he Plan gives to other participants or beneficiaries under the Plan who is not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including open enrollment and special enrollment rights.

2. How long will continuation coverage last?

In the case of a loss of coverage due to end of employment of reduction in hours of employment, coverage generally may be continued only for up to a total of *eighteen (18) months*. In the case of losses of coverage due to an employee's death, divorce, or legal separation, the employee's becoming entitled to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the Plan, coverage may be continued for up to a total of *thirty-six (36) months*. When the qualifying event is the end of employment of reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than *eighteen (18) months* before the qualifying even, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until *thirty-six (36) months* after the date of Medicare entitlement. This notices shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

a. Any required premium is not paid in full on time;
b. A qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary;
c. A covered employee becomes entitled to Medicare benefits (under Part, Part B, or both) after electing continuation coverage; or
d. The employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

3. How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify Sanford Health Plan's Enrollment Coordinator of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

Members who have elected COBRA **and** are disabled according to a Social Security Determination, are responsible to notify Sanford Health Plan by calling Member Services toll free at 1-800-752-5863 or (605) 328-6800.

An *eleven (11) month* extension of coverage may be available if any of the qualified beneficiaries is determined by the Social Security Administration (SSA) to be disabled. The disability has to have started at some time before the *sixtieth (60^{th}) day* of COBRA continuation coverage and must last at least until the end of the *eighteen (18) months* period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the *eleven (11) month* disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan of that fact within *thirty (30)* days of the date listed on your Certificate of Award from SSA.

Second Qualifying Event

An *eighteen (18) month* extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first *eighteen (18) months* of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is *thirty-six (36) months*. Such second qualifying events may include the death of a covered employee, divorce or separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event has not occurred. You must notify the Plan within *sixty (60)* days after a second qualifying event occurs if you want to extend your continuation coverage.

4. How can you elect COBRA continuation coverage?

It is the Employer's responsibility to notify Sanford Health Plan of the occurrence of qualifying events within *thirty (30)* days.

To elect continuation coverage, you must call Member Services toll free at 1-800-752-5863 or (605) 328-6800 and complete the Plan's Election Form. The election period to request a continuation of coverage will expire *sixty (60)* days from the date of the Member's election notice. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee of the employee's spouse can elect continuation coverage on behalf of all the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a *sixty-three (63)* day gap in health coverage, and election of continuation coverage may held you not have such a gap. Second you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take in to account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within *thirty (30)* day*s* after your group health coverage ends because of the qualifying even listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

5. How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension to continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated Plan participant of beneficiary who is not receiving continuation coverage. The required payment for each continuation coverage period for each option is described in the COBRA Notification Letter.

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282 for more information about these new tax provisions.

6. When and how must payment for COBRA continuation coverage made.

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the COBRA Election Form. However, you must make your first payment no later than *forty-five (45)* days after the date of your election. (This is the date the Election Notice is post-marked, if mailed). If you do not make your first payment for continuation coverage in full no later than *forty-five (45)* days after the date of your election, you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact Sanford Health Plan's Enrollment Coordinator to confirm the correct amount of your first payment.

Periodic payments for continuation of coverage

After you make your first payment for continuation coverage, you will be required to make periodic payment for each subsequent coverage period. The amount due for each coverage period for each qualified beneficiary is shown in the COBRA Notification Letter. The periodic payments can be made on a monthly basis. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of each month for that coverage period. If you make a periodic payment of on before the first day of each month, your coverage under the Plan will continue for that coverage period without any break. The Plan **will not** send periodic notices of payments due for these coverage periods.

Grace Periods for periodic payments

Although periodic payments are due on the first day of each month, you will be given a grace period of *thirty (30)* days after the first day of the coverage period to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the coverage period to which applies, but before the end of the grace period for the coverage period, your coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is received. This means that any claims you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

Your first payment and all periodic payments for continuation coverage should be sent to: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110.

7. For more information

More information about continuation coverage and your rights under the Plan is available from the Plan by calling Member Services toll free at 1-800-752-5863 or (605) 328-6800.

For more information about your rights under COBRA, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) by calling the toll free Employee and Employer Hotline at 1-866-444-EBSA (3272) or visit the EBSA website at www.dol.gov/ebsa.

8. Keep your Plan informed of Address Changes

In order to protect you and your family's rights, you should keep the Plan informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan.

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

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

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

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

occurred, provided that the child is added within the appropriate time frames set forth in This Contract.

Subscribers and their Covered Dependents generally have a right to continue coverage for *eighteen (18)* months from the date of the qualifying event if the qualifying event is termination of the Subscriber's employment or a reduction in work hours. For all other qualifying events, coverage shall continue for *thirty-six (36)* months from the date of the qualifying event. In the case of individuals who are disabled within the meaning of the *Social Security Act*, special rules may apply to extend coverage of an additional 11 months. See section on *Extended Coverage for Disabled Person* below. However, the right to continue Group coverage ceases upon the happening of certain events specified in the law, such as becoming eligible for Medicare, the employer ceasing to offer Group coverage, the employer failing to pay Service Charges timely, becoming covered under other coverage in which there is no limitation on coverage due to prior health conditions other than an exclusion or limitation which does not apply to the qualified beneficiary by reason of Chapter 100 of the Internal Revenue Code of 1986, Title I, Part 7 of the Employee Retirement Income Security Act of 1974 or Title XXVII of the Public Health Services Act, or, in the case of a qualified beneficiary who is disabled during the first *sixty (60)* days of continuation coverage, the month that begins more than *thirty (30)* days after the date of final determination that the qualified beneficiary is no longer disabled for Social Security purposes.

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

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

Subsequent Service Charge payments will be allowed a *thirty-one (31)* day grace period after the due date. The Plan will bill the Member directly and payment will be made directly to the Plan.

b. Enrollment and Benefit Changes:

i. if the Group changes benefits, the Subscriber's benefits will also change to match the Group's new benefit package.

ii. the Subscriber has the same right to change benefit programs as the active Group Members. A Pre-Existing Condition waiting period may not be applied to a transferring Subscriber and his or her covered Dependents.

iii. if the Group changes plans or insurers during the period of Continued Group Benefits, the Subscribers for the Group will be canceled as to coverage under this Contract and become the responsibility of the new health plan or insurer.

c. Extended Coverage Period for Disabled Persons: Continuous Coverage can be extended from *eighteen to twenty-nine (18 to 29)* months for individuals who are disabled according to Social Security regulations at the time of termination or reduction in hours or within *sixty (60)* days of coverage under Continuous Coverage. Coverage is extended to *twenty-nine (29)* months for the disabled individual and qualified family members. To be eligible for the additional *eleven (11)* months of coverage, the Subscriber Eligible Dependent must notify the Plan of the disability within *sixty (60)* days of receiving approval from Social Security for disability benefits, but before the *eighteen (18)* month period expires. The premium for the additional *eleven (11)* months will be 150% of the full premium in effect at that time.

d. Exceptions. Continuation of Coverage is <u>not</u> available if any of the following apply:

i. the Member is covered for similar benefits through individual or group coverage;
ii. the Member is covered by or is eligible for benefits under any state or federal law;
iii. the Member is covered by under sources listed in sections i. or ii. above, together with the continuation coverage, would result in overinsurance;
iv. the Member has committed fraud or made a material misrepresentation in applying for conversion coverage.
v. the Plan has canceled all similar insurance policies in the State; or
vi. the required Service Charge payments are not made when due.

Section 11. 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.

Attachment I. Summary of Plan Benefits

This page intentionally left blank. Your *Summary of Plan Benefits* is an attachment to this Policy.

Out-of-Network Benefit Plan Amendment

This amendment applies only if your *Summary of Plan Benefits* states that your out of network coverage is "zero." This benefit package does not include coverage for out of network benefits. This amendment hereby makes Section 3 (g) of this Policy null and void.

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