

Sanford Employee Health Plan

Summary Plan Description

This Contract has no Out-of-Network coverage except when Urgent or Emergent Care is Medically Necessary. Please read this Certificate of Coverage carefully and pay close attention that you are receiving care from In-Network Participating Practitioner and/or Providers.

Help understanding this document is free.

If you would like it in a different format (for example, in a larger font size), please call us at (800) 752-5863 (*toll-free*) | TTY/TDD: 711 (*toll-free*).

Help in a language other than English is also free.

Please call (800) 752-5863 (*toll-free*) to connect with us using free translation services.



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Free Help in Other Languages

This Medical Benefit Plan replaces any prior plan you may have had. We hope you find it easy to read and helpful in answering your health coverage questions. It is the legal document representing your coverage, so please keep it in a safe place where you can easily find it.

If you have any questions, for example about your benefits, this document, or how Sanford Health Plan pays for your care, please call us toll-free at the number below.

For help in a language other than English, please call us toll-free at (800) 752-5863. Both oral and written translation services are available for free in at least 150 languages.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 800-752-5863 (رقم هاتف الصم والبكم: 711).

Amharic - ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 800-752-5863 (መስማት ለተሳናቸው: 711)፡፡

Chinese - 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 800-752-5863 (TTY: 711)。

Cushite (Oromo) - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 800-752-5863 (TTY: 711).

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 800-752-5863 (TTY: 711).

Hmong - LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 800-752-5863 (TTY: 711).

Karen - ဟံသာဝတီသား- နမ့်ကတိကညီ ကျိန်အယိ, နမ့်နွံ ကျိန်အတိမာစာလၢ တလၢ်ဘျုးလၢ်စုၤ နီတံၤဘျုးသ့န့ၣ်လီၤ. ကိ: 800-752-5863 (TTY: 711).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 800-752-5863 (TTY: 711) 번으로 전화해 주십시오.

Laotian - ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 800-752-5863 (TTY: 711).

French - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 800-752-5863 (ATS: 711).

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 800-752-5863 (телетайп: 711).

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 800-752-5863 (TTY: 711).

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 800-752-5863 (TTY: 711).

Thai - เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 800-752-5863 (TTY: 711).

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 800-752-5863 (TTY: 711).

Notice

Your employer has established a self-funded employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Summary Plan Description is provided to you in accordance with the Employee Retirement Income Security Act of 1974 (ERISA).

This document, which is called the **Summary Plan Description (hereinafter the SPD or Plan)**, describes the Medical Benefit Plan (herein called the Plan) as established and self-funded by **Sanford** (herein called the Employer or Sponsor). This Summary Plan Description serves as both the SPD and is the official benefit plan document for the employee welfare benefit plan established by the Plan Administrator.

The **Claims Administrator** shall have full, final, and complete discretion, to construe and interpret: the Summary Plan Description and related documents, procedures and/or standards, including doubtful or disputed terms; and to conduct any and all reviews of claims and appeals, denied in whole or in part. The decision of the Claims Administrator shall be final, conclusive and binding upon all parties, except with respect to enrollment and eligibility. The **Plan Administrator** shall have final authority on all enrollment and related eligibility determinations.

IMPORTANT: This is not an insured-benefit Plan. **Sanford Health Plan (SHP)** provides claims administration services to the Plan, but Sanford Health Plan does not insure the benefits described herein. The benefits described in this Summary Plan Description, as well as any attachments or amendments appended hereto, are **self-insured** by the Employer, who is responsible for their payment.

General Information

ERISA requires that certain information be furnished to each Employee eligible for the Plan. The following information, together with the information contained in your Summary of Benefits and Coverage (SBC), your Formulary, and any amendments or material modifications, comprise the Summary Plan Description (SPD) under ERISA.

Name of Plan

The designated name of the plan is Sanford Employee Health Plan.

Plan Sponsor (Employer)

The name and address of the entity that established, and maintains, the Plan is:

Sanford
801 Broadway North
Fargo, ND 58102
(877) 243-1372

Plan Sponsor's Employer Identification Number

27-1218956

Plan Administrator

Sanford
801 Broadway North
Fargo, ND 58102
(877) 243-1372

Claims Administrator

Sanford Health Plan
4800 W 57th St
Sioux Falls, SD 57108
(800) 752-5863 | TTY: 711

Plan Effective Date

January 1, 1965

Plan Year End Date

The Plan's records are maintained on a calendar year basis beginning each plan year on January 1st and ending on December 31st.

Plan Number

501

Type of Plan

The Plan is an Employee welfare benefit plan providing group medical benefits, funded from the general assets of the Plan Sponsor.

This Plan Is Not an Employment Contract

The Plan and Summary Plan Description are not to be construed as a contract for, or of, employment.

Clerical Error

Any clerical error by the Plan Administrator or an agent of the Plan Administrator, in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment.

The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

Amending and Terminating the Plan

If the Plan is terminated, the rights of the Participants are limited to expenses incurred before termination. The Employer reserves the right, at any time, to amend, suspend or terminate the Plan, in whole or in part

Procedure for Amending the Plan

The Plan Sponsor reserves the right to and may amend the Plan from time to time by written instrument. You will be notified should such a change occur, in accordance with the provisions of ERISA.

Statement of Eligibility to Enroll

Employees are eligible for benefits as designated by the Plan Sponsor.

Eligibility to receive benefits under the Plan is initially determined by the Plan Sponsor. When an eligible employee meets the criteria for eligibility, an enrollment form must be completed. The Plan Sponsor has full discretion to determine eligibility for benefits. The Plan Sponsor's decision shall be final, conclusive and binding upon all parties.

Fiduciary Definitions and Duties

Fiduciary

A fiduciary exercises discretionary authority or control over management of the Plan or has discretionary authority or responsibility in the administration of the Plan.

Fiduciary Responsibilities

A fiduciary must carry out the duties and responsibilities in the interest of the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These duties must be carried out:

1. With care, skill, prudence and diligence under the given circumstances that a prudent person acting in a like capacity and familiar with such matters, would use in a similar situation;
2. In accordance with the Plan documents.

The Named Fiduciary

A “named fiduciary” is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary, or continuing either the appointment or the procedures; or
2. The named fiduciary breached its fiduciary responsibility under §405(a) of ERISA.

Named Fiduciary

Sanford
801 Broadway North
Fargo, ND 58102
(877) 243-1372

Claims Administrator Is a Fiduciary

The Claims Administrator, SHP, is a Plan fiduciary for benefit claims and appeals only. As such, SHP has the final and discretionary authority to determine claims and appeals, and has the final and discretionary authority to interpret all terms of the Plan and make factual determinations necessary to make the claim and appeal determinations. The decision made by SHP on review is final and binding, subject to your right to file a lawsuit under ERISA or other applicable law. This decision-making authority is limited only by the duties imposed under ERISA. Any determination by SHP is intended to be given deference by courts to the maximum extent allowed under ERISA. In no event, however, shall SHP be responsible or liable for any benefit payments due under the Plan.

How the Plan is Administered

Procedure for Allocation of Responsibilities

The Plan Administrator shall use its sole discretion to determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents.

SHP, acting on behalf of the Plan Administrator, shall have full and discretionary authority to make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan.

Any construction of the terms of any plan document and any determination of fact adopted by the Plan, or SHP, acting on behalf

of the Plan Administrator, shall be final and legally binding on all parties.

Any interpretation, determination, or other action of the Plan Administrator shall be subject to review only if it is arbitrary, capricious, or otherwise an abuse of discretion. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of review.

If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, reference herein to the Plan Administrator shall be deemed to include reference to such delegate.

Delegation of Authority

If any of the authority of the Plan Administrator has been delegated by the Plan Administrator to a delegate, reference herein to the Plan Administrator shall be deemed to include reference to such delegate.

Plan Administrator

Sanford is the Plan Sponsor and Plan Administrator. The Plan is to be administered by the Plan Administrator, and/or its designees, in accordance with the provisions of ERISA and the Plan document.

Agent for Legal Service

Sanford
801 Broadway North
Fargo, ND 58102

Plan Administrator Compensation

The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

Duties of the Plan Administrator:

1. To delegate the administration of the Plan in accordance with terms established by the Plan Administrator.
2. To interpret the Plan, including the right to resolve possible ambiguities, inconsistencies or omissions, in consultation with the Claims Administrator.
3. To decide enrollment and/or eligibility disputes that may arise relative to a Participant's rights under the Plan.
4. To prescribe procedures for filing a claim for benefits.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims and other duties as outlined in this SPD and the Service Agreement.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA §609.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Duties of the Claims Administrator as a Limited Fiduciary:

1. To administer the Plan in accordance with its terms as set by the Plan Administrator.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To follow the Plan Administrator's procedures for reviewing complaints that may arise under the Plan relative to a Participant's rights.
4. To follow the Plan Administrator's procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain Plan documents and any other record while the Plan is administered by the Claims Administrator.
6. To administer benefits, as specified in this SPD, in accordance with a medical child support order [ERISA §609].
7. To delegate to any person or entity such powers, duties, and responsibilities as it deems appropriate in accordance with the Claim Administrator's limited fiduciary role stated in the Service Agreement.

Title of Employees Authorized To Receive Protected Health Information

These identified individuals will have access to the Participant's Protected Health Information only to perform the plan administrative functions the Plan Administrator provides to the Plan.

- Broker/Agent
- Controller
- President/CEO
- CFO
- Payroll & Benefits
- Senior HR Director

This includes every employee, class of employees, or other workforce person under control of the Plan Administrator who may receive the Participant's Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Benefit Plan in the ordinary course of business. Such individuals will be subject to disciplinary action for any use or disclosure of the Participant's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Plan Administrator shall promptly report any such breach, violation, or noncompliance to the Plan Administrator; will cooperate with the Plan Administrator to correct the breach, violation and noncompliance to impose appropriate disciplinary action on each employee or other workforce person causing the breach, violation, or noncompliance; and will mitigate any harmful effect of the breach, violation, or noncompliance on any Participant whose privacy may have been compromised.

Any such breach discovered by the Plan Sponsor, shall be reported to SHP within sixty (60) days of such breach.

Funding the Plan and Payment of Benefits

The cost of the Plan is funded as follows:

The level of any Employee contributions is set by the Plan Sponsor. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction, and shall be used prior to Plan Sponsor funding.

Benefits are paid directly from the Plan Sponsor to SHP (which serves as a conduit to forward payment to providers). SHP, as SHP is a mere claims-paying agent of the Plan Sponsor. All reimbursements are paid out of the general assets of the employer, and there is no separate fund or account that secures the promised benefit

Individuals covered by this Plan include all Eligible Employees, and Eligible Dependents of the Plan Sponsor. This plan is *unfunded* for purposes of compliance with Title I of ERISA.

Summary Notice and Important Phone Numbers

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Summary Plan Description for group health insurance carefully. If you have any questions about the benefits as presented in the Summary Plan Description, please contact the Employer, as Plan Administrator, or use the information below to contact SHP, the Claims Administrator.

Method	Sanford Health Plan Contact Information
CALL	(800) 752-5863 <i>calls to this number are free</i>
TTY	711
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com or www.sanfordhealthplan.com/memberlogin
TRANSLATION SERVICES	(800) 752-5863
WRITE	Sanford Health Plan PO Box 91110 Sioux Falls, SD 57109-1110
PHYSICAL ADDRESS	Sanford Health Plan 4800 W 57 th St Sioux Falls, SD 57108

How to contact Customer Service

For assistance with claim inquiries/status, eligibility and enrollment, provider access, and order ID cards, please call or write to Customer Service. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Customer Service Contact Information
CALL	(800) 752-5863 <i>calls to this number are free</i>
TTY	711
FAX	(605) 328-6812
HOURS	7:30 a.m. to 5 p.m. Central time, Monday – Friday
WEBSITE	www.SanfordHealthPlan.com
WRITE	Sanford Health Plan Customer Service PO Box 91110 Sioux Falls, SD 57109-1110

How to contact us with questions about Certification (prior authorization)

Some of the services listed in this document are covered only if your doctor or other network provider gets approval in advance (called Certification or prior authorization) from us. The Utilization Management department handles all certification requests. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Utilization Management Contact Information
CALL	(800) 805-7938 <i>calls to this number are free</i>
TTY	711
FAX	(605) 328-6813
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Utilization Management PO Box 91110 Sioux Falls, SD 57109-1110

How to contact Pharmacy Management

For assistance with pharmacy benefit questions, formularies, or drug pre-authorization, please call or write to Pharmacy Management.

Method	Pharmacy Management Contact Information
CALL	(800) 752-5863 <i>calls to this number are free</i>
TTY	711
FAX	(701) 234-4568
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Pharmacy Management PO Box 91110 Sioux Falls, SD 57109-1110

How to contact Appeals and Grievances

For assistance with Complaints (grievances) and appeal rights, contact the Appeals and Grievances department. A confidential voicemail is available after hours and on weekends. All inquiries will be returned within one business day.

Method	Appeals and Grievances Contact Information
CALL	(800) 752-5863 <i>calls to this number are free</i>
TTY	711
HOURS	8 a.m. to 5 p.m. Central time, Monday – Friday
WRITE	Sanford Health Plan Appeals and Grievances Department PO Box 91110 Sioux Falls, SD 57109-1110

Privacy and HIPAA Disclosure Notices

Use and Disclosure of Your Personal Health Information

As a Business Associate of the Plan, SHP has an agreement with the Plan that allows SHP to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA, through its role as Claims Administrator. In addition, by applying for coverage and participating in the Plan, SHP may obtain, use and release all records about you, and/or any Covered Dependents, that it needs to administer the Plan or to perform any functions authorized or permitted by law.

DISCLOSURES TO THE PLAN SPONSOR

In order for your benefits to be properly administered, Sanford Health Plan needs to share your protected health information with the Plan Sponsor (your employer).

Here are the circumstances under which Sanford Health Plan may disclose your protected health information (PHI) to the Plan Sponsor:

1. SHP may inform the Plan Sponsor whether you are enrolled in the Plan.
2. SHP Plan may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from the insurer or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
3. SHP Plan may disclose your protected health information to the Plan Sponsor for Plan administrative purposes. This is because Employees of the Plan Sponsor perform some of the administrative functions necessary for the management and operation of the Plan.

Here are the restrictions that apply to the Plan Sponsor's use and disclosure of your protected health information:

- The Plan Sponsor will only use or disclose your protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See Notice of Privacy Practices for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the Plan discloses any of your protected health information to any of its agents or subcontractors, the Plan will require the agent or subcontractor to keep your protected health information as required by the HIPAA regulations.
- The Plan Sponsor will not use or disclose your protected health information for employment-related actions or decisions, or in connection with any other benefit or benefit plan of the Plan Sponsor.
- The Plan Sponsor will promptly report to SHP any use or disclosure of your protected health information that is inconsistent with the uses or disclosures provided for in this Summary Plan Description and the Service Agreement.
- The Plan will allow you SHP to inspect and copy any protected health information about you that is in the Plan's custody and control. The HIPAA regulations set forth the rules that you and the Plan must follow in this regard. There are some exceptions.
- The Plan will amend, or allow SHP to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.
- With respect to some types of disclosures, the Plan will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2003). You have a right to see the disclosure log. The Plan does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations.
- The Plan will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to SHP and to the U.S. Department of Health and Human Services, or its designee.
- The Plan will, if feasible, return or destroy all of your protected health information in the Plan's custody or control that the Plan has received from SHP or from any business associate when the Plan no longer needs your protected health information to administer the Plan. If it is not feasible for the Plan to return or destroy your protected health information, the Plan will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.
- The classes of Employees or other workforce members listed in this booklet under the control of the Plan may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained and as outlined on page iv.

- The Plan Sponsor's Human Resources Department, including its employees tasked with coordinating benefits, and/or other staff as appropriate, for the administration of the Plan.
- If any of the foregoing Employees or workforce members of the Plan use or disclose your protected health information in violation of the rules that are explained above, its employees, or workforce members, will be subject to disciplinary action and sanctions - which may include termination of employment. If the Plan Sponsor becomes aware of any violation like this, the Plan Sponsor will promptly report the violation to SHP and will cooperate with it to correct the violation; impose appropriate sanctions; and mitigate any harmful effects to you.

Notice of Privacy Practices

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

This Notice of Privacy Practices ("Notice") applies to SHP [herein known as "we"/"us"/"our"]. If you have questions about this Notice, please contact Customer Service at (800) 752-5863 (*toll-free*) | TTY: 711 (*toll-free*).

This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by SHP, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways. Unless otherwise provided by law, any data or information pertaining to the health, diagnosis, or treatment of a Participant under a policy or contract, or a prospective Participant, obtained by Sanford Health Plan from that person or from a health care Provider, regardless of whether the information is in the form of paper, is preserved on microfilm, or is stored in computer-retrievable form, is confidential and may not be disclosed to any person except as set forth below.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

We use or disclose your health information as follows (In Minnesota we will obtain your prior consent):

- **Help manage the health care treatment you receive:** We can use your health information and share it with professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional services.
- **Pay for your health services:** We can use and disclose your health information as we pay for your health services. For example, we share information about you with your Primary Care Practitioner and/or Provider to coordinate payment for those services.
- **For our health care operations:** We may use and share your health information for our day-to-day operations, to improve our services, and contact you when necessary. For example, we use health information about you to develop better services for you. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.
- **Administer your plan:** We may disclose your health information to your Plan for plan administration.

We may share your health information in the following situations unless you tell us otherwise. If you are not able to tell us your preference, we may go ahead and share your information if we believe it is in your best interest or needed to lessen a serious and imminent threat to health or safety:

- **Friends and Family:** We may disclose to your family and close personal friends any health information directly related to that person's involvement in payment for your care.
- **Disaster Relief:** We may disclose your health information to disaster relief organizations in an emergency.

We may also use and share your health information for other reasons without your prior consent:

- **When required by law:** We will share information about you if federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- **For public health and safety:** We can share information in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone's health or safety.
- **Organ and tissue donation:** We can share information about you with organ procurement organizations.
- **Medical examiner or funeral director:** We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers' compensation and other government requests:** We can share information to employers for Workers' compensation claims. Information may also be shared with health oversight agencies when authorized by law, and other special government functions such as military, national security and presidential protective services.
- **Law enforcement:** We may share information for law enforcement purposes. This includes sharing information to help

locate a suspect, fugitive, missing person or witness.

- **Lawsuits and legal actions:** We may share information about you in response to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for certain research projects that have been evaluated and approved through a process that considers patient's need for privacy.

We may contact you in the following situations:

- **Treatment options:** To provide information about treatment alternatives or other health related benefits or Plan services that may be of interest to you.
- **We will not use your information for marketing or fundraising, and will not sell your information.**

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION

When it comes to your health information, you have certain rights:

- **Get a copy of your health and claims records:** You can ask to see or get a paper or electronic copy of your health and claims records and other health information we have about you. We will provide a copy or summary to you usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your health and claims records:** You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we will tell you why in writing. These requests should be submitted in writing to the contact listed below.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be approved. We must say "yes" if you tell us you would be in danger if we do not.
- **Ask us to limit what we use or share:** You can ask us to restrict how we share your health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **Get a list of those with whom we have shared information:** You can ask for a list (accounting) of the times we have shared your health information for six (6) years prior, who we have shared it with, and why. We will include all disclosures except for those about your treatment, payment, and our health care operations, and certain other disclosures (such as those you asked us to make). We will provide one (1) accounting a year for free, but we will charge a reasonable cost-based fee if you ask for another within twelve (12) months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated:** You can complain to the U.S. Department of Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.
- **Claims Administrator Contact Information:**

Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110
(800) 752-5863 (toll-free) | TTY: 711
(toll-free)

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

- We are required by law to maintain the privacy and security of your health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your health information.
- We must follow the duties and privacy practices described in this Notice and offer to give you a copy.
- We will not use, share, or sell your information for marketing or any purpose other than as described in this Notice unless you tell us to in writing. You may change your mind at any time by letting us know in writing. We will not use genetic

information for underwriting purposes.

CHANGES TO THIS NOTICE

We may change the terms of this Notice, and the changes will apply to all information we have about you. The new Notice will be available upon request and on our website at www.sanfordhealthplan.com.

EFFECTIVE DATE

This Notice of Privacy Practices is effective on the effective date of the Plan.

NOTICE OF AFFILIATED COVERED ENTITY DESIGNATION

Sanford Health Plan, Sanford Health, and The Evangelical Lutheran Good Samaritan Society, as covered entities under common ownership and control, have designated themselves and subsidiaries as a single covered entity for purposes of the Health Insurance Portability and Accountability Act (HIPAA). Sanford Health Plan shares health information about its members with the affiliated covered entity participants for treatment and other purposes as allowed by HIPAA and applicable law.

Introduction

Participant Rights

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

1. Participants have the right to refuse treatment.
2. Participants have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; gender; gender identity; sexual orientation; medical condition; including current or past history of a mental health and substance use disorder; disability; religious beliefs; national origin; age; or sources of payment for care.
3. Participants have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
4. Participants have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
5. Participants 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.
6. Participants 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, North Dakota, Minnesota, and Iowa law.
7. Participants have the right to know the identity and professional status of individuals providing service to them and to know which physician or other practitioner is primarily responsible for their individual care. Participants also have the right to receive information about our clinical guidelines and protocols.
8. Participants have the right to a candid discussion with the practitioner(s) and/or Provider(s) 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. Participants also have the right to participate with practitioners and/or Providers in decision-making regarding their treatment plan.
9. Participants have the right to give informed consent before the start of any procedure or treatment.
10. When Participants do not speak or understand the predominant language of the community, the Plan will provide access to an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the participant.
11. Participants have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and read.
12. Participants have the right to a clear grievance and appeal process for complaints and comments and to have their issues resolved in a timely manner.
13. Participants have the right to appeal any decision regarding medical necessity made by the Plan and its practitioners and/or providers.
14. Participants have the right to terminate coverage under the Plan, in accordance with applicable Employer and/or Plan guidelines.
15. Participants have the right to make recommendations regarding the organization's member's rights and responsibilities policies.
16. Participants have the right to receive information about the organization, its services, its practitioners and providers and Participants' rights and responsibilities policies.
17. Participants have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, or the use of restraints and seclusion.

Participant Responsibilities

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

1. Participants have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible practitioner. Participants are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
2. Participants are responsible for carrying their Plan ID cards with them and for having member identification numbers available when telephoning or contacting the Plan, or when seeking health care services.
3. Participants are responsible for following all access and availability procedures.
4. Participants are responsible for seeking emergency care at a Plan participating emergency facility whenever possible. In the event an ambulance is used, Participants are encouraged to direct the ambulance to the nearest participating emergency facility unless the condition is so severe that you must use the nearest emergency facility. State laws require that the ambulance transport you to the hospital of your choice unless that transport puts you at serious risk.
5. Participants 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 or as soon as reasonably possible.
6. Participants are responsible for keeping appointments, and when they are unable to do so for any reason, for notifying the responsible practitioner or the hospital.
7. Participants are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Participants are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health care conditions, including mental health and/or substance use disorders.
8. Participants are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
9. Participants are responsible for providing name, address, or telephone number changes within thirty (30) days. Participants who purchased an Individual plan should call Sanford Health Plan at (800) 752-5836 (TTY: 711). Participants with an employer group plan must notify their employer/Plan Sponsor, who is responsible for notifying the Plan.
10. Participants are responsible for reporting any changes of eligibility that may affect their membership or access to services. Participants who purchased an Individual plan should call Sanford Health Plan at (800) 752-5836 (TTY: 711). Participants with an employer group plan must notify their employer/Plan Sponsor, who is responsible for notifying the Plan.

Special Communication Needs

Please call SHP if you need help understanding written information at (800) 752-5863 (*toll-free*). We can read forms to you over the phone and we offer free oral translation in any language through our translation services.

Translation Services

SHP can arrange for translation services. Free written materials are available in several different languages and free oral translation services are available. Call toll-free (800) 752-5863 for help and to access translation services.

Services for the Deaf, Hearing Impaired, and/or Visually Impaired

If you are deaf or hearing impaired and need to speak to SHP, call TTY: 711 (*toll-free*). Please contact SHP at (800) 752-5863 if you are in need of a large print copy or cassette/CD of any of SHP's written materials.

Notice of Rights and Protections under ERISA

The following ERISA rights are required by federal law and regulation. As a Participant in the Plan, you are entitled to certain rights and protection under the Employee Retirement Security Act of 1974 (ERISA).

ERISA provides that all Plan Participants shall be entitled to:

1. Receive Information About Your Plan and Benefits

- a. Examine, without charge, at the Plan Sponsor's office and at other specified locations such as worksites, all Plan documents governing the Plan, including insurance contracts, the latest Summary Plan Description, and copies of all documents filed by the Plan Sponsor, such as Form 5500 Series Summary Annual Reports (SAR) (Form 5500 Series) with the U.S. Department of Labor;
- b. Obtain copies of all Plan Documents and other Plan information upon written request to the Plan Sponsor. The administrator may make a reasonable charge for the copies; and
- c. Receive a summary of the Plan Sponsor's annual financial report. The Plan Sponsor is required by law to furnish each Participant with a copy of this summary annual report.

2. Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse/domestic partner or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

3. Prudent Actions by Plan Fiduciaries

In addition to creating rights for Participants, ERISA imposes obligations upon the persons who are responsible for the operation of this Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Participants and beneficiaries. No one, including your Employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

4. Enforce Your Rights

- a. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. You have a right to have the Plan Sponsor review and reconsider your claim.
- b. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan Sponsor, and do not receive them within thirty (30) days, you may file suit in a federal court. In such case, the court may require the Plan Sponsor to provide the materials and pay up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.
- c. If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted SHP's claims procedures, you may file suit in court. In addition, if you disagree with SHP's decision, or lack thereof, concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court.
- d. If it should happen that the Plan fiduciaries misuse the Plan Sponsor's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person or entity you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

5. Assistance with Your Questions

- a. If you have questions about your Plan, you should contact the Plan Sponsor. If you have any questions about this statement, or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Administration, U.S. Department of Labor; the contact information for your nearest office is:

Kansas City Regional
Office 2300 Main St., Ste.

1100 Kansas City, MO
64108

Tel (816) 285-1800 Fax (816) 285-1888

- b. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration or contact the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor at 200 Constitution Avenue N.W., Washington, D.C. 20210.

Fraud

Fraud is a crime that can be prosecuted. Any Participant who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud.

As a Participant, you must:

1. File accurate claims. If someone else files claims on your behalf, you should review the form before you sign it;
2. Review the Explanation of Benefits (EOB) form when it is returned to you. Make certain that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered;
3. Never allow another person to seek medical treatment under your identity. If your ID card is lost, you should report the loss to SHP immediately; and
4. Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge. If you are concerned about any of the charges that appear on a bill, Explanation of Benefits, form, or other document; or if you know of or suspect any illegal activity, call SHP toll-free at (800) 752-5863 | TTY: 711 (*toll-free*). All calls are strictly confidential.

Physical Examinations

SHP, at the Plan's expense, may require a physical examination of the Participant when medically necessary during the pendency of a Claim for Benefits and may require an autopsy in case of death, if the autopsy is not prohibited by law.

Service Area

The Plan uses the network of Sanford Health Plan, as described below:

- In **South Dakota** the Service Area for Sanford Health Plan includes all counties in the state.
- In **North Dakota** the Service Area for Sanford Health Plan includes all counties in the state.
- In **Iowa** the Service Area for Sanford Health Plan includes the following counties: Clay, Dickinson, Emmet, Ida, Lyon, Osceola, O'Brien, Plymouth, Sioux, Woodbury
- In **Minnesota** the Service Area for Sanford Health Plan includes the following counties: Becker, Beltrami, Big Stone, Blue Earth, Brown, Chippewa, Clay, Clearwater, Cottonwood, Douglas, Grant, Hubbard, Jackson, Kandiyohi, Kittson, Lac Qui Parle, Lake of the Woods, Lincoln, Lyon, Mahnomen, Marshall, Martin, McLeod, Meeker, Murray, Nicollet, Nobles, Norman, Otter Tail, Pennington, Pipestone, Polk, Pope, Red Lake, Redwood, Renville, Rock, Roseau, Sibley, Stearns, Stevens, Swift, Traverse, Watonwan, Wilkin, Yellow Medicine

Medical Terminology

All medical terminology referenced in this Summary Plan Description follows the industry standard definitions of the American Medical Association.

Definitions

Capitalized terms are defined in this Summary Plan Description in Section 11.

Value-Added Program Disclosure

SHP may, from time to time, offer health or fitness related programs to our Participants through which Participants may

access discounted rates from certain vendors for products and services available to the general public. Products and services available under any such program are not Covered Services. Any such programs are not guaranteed and could be discontinued at any time. SHP does not endorse any vendor, product or service associated with such a program and the vendors are solely responsible for the products and services you receive.

Conformity with Federal Laws and Regulations

Any provision in this SPD that is not in conformity with applicable federal laws, rules, or regulations may not be rendered invalid but is to be construed and applied as if it were in full compliance with such laws, rules, or regulations.

As federal regulations change, your coverage may also change. In such instances, you will be notified by the Plan.

Limitation Period for Filing Suit

No legal action may be brought for payment of benefits under this Benefit Plan prior to a Participant completing the administrative appeal process. A suit for benefits under this Plan must be brought within two (2) years after the expiration of the time within which notice of a Claim for Benefits is required by this Benefit Plan. See Sections 2 and 10 for applicable timelines and details on appealing an Adverse Determination.

Notice of Non-Discrimination

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew a SPD, (b) terminate coverage, (c) limit benefits, or (d) charge a different Service Charge.

Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages
- If you need these services, contact Sanford Health Plan at (800) 752-5863.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by contacting the Section 504 Coordinator.

Section 504 Coordinator

2301 E. 60th Street

Sioux Falls, SD 57104

Phone: (877) 473-0911 | TTY: 711

Fax: (605) 312-9886

Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by mail, fax, phone, or email. If you need help filing a grievance, the Section 504 Coordinator is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Summary of Benefits & Coverage

Your Summary of Benefits and Coverage is available in One Source (Workday) on the Total Rewards Dashboard. Printed versions are available free of charge by contacting your local Sanford Human Resources Department.

Section 1. Enrollment

1.1 Employee Eligibility

Employee Eligibility is defined in the benefits eligibility policy. The Plan Sponsor has the ultimate decision making authority regarding eligibility to enroll and become eligible for benefits. With questions regarding benefit eligibility, contact your Plan Administrator.

1.2 When to Enroll

To become a Participant, an Eligible Employee must enroll within the applicable Initial Enrollment Period or any Open Enrollment Period. Open Enrollment is a period of time when Eligible Employees may enroll themselves and their Eligible Dependents in the Plan.

Late Enrollees

A “Late Enrollee” is an Eligible Employee or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage. “Late Enrollees” may not enroll at any time during the year other than during the next scheduled Open Enrollment Period. A Participant is not a “Late Enrollee” if special enrollment rights apply, as described later in this Section. If an Employee wishes to make a benefit election change after thirty (30) days from a qualified life event in which special enrollment rights apply, the employee must wait until the next annual open enrollment period.

1.3 Timely, Open, or Late Enrollment

Timely Enrollment

An enrollment will be “timely” if completed:

- during the open enrollment period, or
- within thirty (30) days after the person becomes eligible to enroll, in accordance with Employee/Dependent Eligibility requirements; or
- under a Special Enrollment Period.

Open Enrollment

Prior to the start of a Coverage/Benefit Year, this Plan has an Open Enrollment Period. “Open Enrollment Period” means the period of time occurring toward the end of the Coverage Year during which:

- a. Eligible Employees who are not covered under this Plan may elect to begin coverage effective the first day of the upcoming Coverage Year; and
- b. Participants will be given an opportunity to change their coverage effective the first day of the upcoming Coverage Year.

The terms of the open enrollment period, including duration of the election period, shall be determined by the Plan Administrator/Sponsor and communicated prior to the start of an open enrollment period.

Late Enrollment

1. A “Late Enrollee” is an Eligible Employee or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage.
2. Late Enrollees and their Dependents who either are not eligible to join the Plan or choose not to elect coverage may only join during a subsequent open enrollment period.
3. A Participant is not a “Late Enrollee” if special enrollment rights apply, as described later in this SPD.
4. If an Employee wishes to make a benefit election change after 30 days from a qualified life event, during which special enrollment rights applied, the employee must wait until the next annual open enrollment period.

If an individual loses eligibility for coverage as a result of terminating employment, or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment, or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

1.4 Status of Participant Eligibility

The Plan Administrator agrees to furnish SHP with any information required by SHP for the purpose of enrollment. Any changes affecting a Participant's eligibility for coverage must be provided to SHP by the Plan Administrator and/or the Participant immediately, but in any event, the Plan Administrator and/or the Participant shall notify SHP within 30 days of the change.

Statements made in connection with Plan enrollment are deemed representations and not warranties. A Participant making a statement (including the omission of information) in connection with Plan enrollment, or in relation to any of the terms of this Benefit Plan, constituting fraud or an intentional misrepresentation of a material fact will result in the Rescission of coverage under of this Benefit Plan. A rescission is a cancellation or discontinuance of coverage, including any benefits paid, that has a retroactive effect of voiding this Benefit Plan or any benefits paid under the terms of this Benefit Plan.

1.5 How to Enroll

Both the Plan Sponsor and Participant are involved in the enrollment process.

The Participant must:

1. Complete the enrollment process, as designated by the Plan Sponsor, for the Eligible Employee and any Eligible Dependents; and
2. Provide all information needed to determine the eligibility of the Eligible Employee and/or Dependents, if requested by the Plan.

The Plan Sponsor must provide all information needed by SHP to effectuate coverage.

1.6 When Coverage Begins

The effective date for coverage under the Plan is determined by the Plan Sponsor to effectuate coverage are not immediately met, 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.

If you are an inpatient in a Hospital or other Facility on the day your coverage begins, the Plan will pay benefits for Covered Services that you receive beginning on the date your coverage becomes effective, as long as you receive Covered Services in accordance with the terms of this SPD. Payment of benefits is subject to this Plan's Coordination of Benefit provisions and any obligations under a previous plan or coverage arrangement, in accordance with applicable regulations. For more information, see Section 6, "*Coordination of Benefits*".

USERRA Reinstatement

Special rules apply to those Eligible Employees whose coverage is reinstated following a leave of absence governed by the Uniform Services Employment and Reemployment Rights Act of 1994 (USERRA). Under USERRA, a Covered Individual entitled to have coverage reinstated upon returning to work following a military leave of absence shall be treated as if no break in coverage occurred during the leave. For more information regarding USERRA rights, see Section 9, *Options After Coverage Ends*.

1.7 Eligibility Requirements for Dependents

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

Spouse, Common Law Spouse, Domestic Partner

Spouse - The Participant's legal spouse is eligible for coverage, subject to the eligibility requirements as designated by the Plan Sponsor.

Common Law Spouse – To be eligible for coverage the Participant, and their Common Law Spouse, must meet all the following requirements:

- a. Are not in a Common Law marriage relationship with anyone else;
- b. Reside in or move from a state that recognizes Common Law marriages;
- c. Share a principal residence and intend to do so permanently;

- d. Be at least eighteen (18) years of age or older and mentally competent to consent to contract;
- e. Are not blood relatives to a degree of closeness that would prohibit marriage;
- f. Are in a committed and exclusive relationship, jointly responsible for the other's welfare and financial obligations; and
- g. Agree to sign an Affidavit of Common Law Marriage upon enrollment of a common law spouse in this Benefit Plan. *A Notice of Termination of common law marriage will be required upon termination of the relationship with the Participant.*

Domestic Partner – To be eligible for coverage the Participant and their Domestic Partner must meet all the following requirements:

- a. Age 18 or older
- b. Each other's sole domestic partner in a long-term committed relationship and intent to remain so indefinitely
- c. Not legally married under applicable state law
- d. Not related by blood to the Eligible Employee
- e. Capable of Consent
- f. Financially interdependent
- g. Shared residence for 12+ consecutive months
- h. There has been at least six months since the termination of a previous domestic partnership

Dependent Child(ren) and Domestic Partner's Child(ren) - To be eligible for coverage, a Dependent Child and/or Domestic Partner's Child must meet the following requirements:

Dependent Child(ren)

- a. Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child; and meet one of the following requirements:
 - 1. under age twenty-six (26); or
 - 2. incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Participant for support and maintenance. If the Plan so requests, the Participant must provide proof of the child's disability within thirty (30) days of the Plan's request.

Domestic Partner's Child(ren)

- a. Including biological child(ren), a child placed with your Domestic Partner for adoption, a legally adopted child, a child for whom your Domestic Partner has legal guardianship
 - 1. under age twenty-six (26); or
 - 2. incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Participant for support and maintenance. If the Plan so requests, the Participant must provide proof of the child's disability within thirty (30) days of the Plan's request

Coverage extends to the end of the month in which the Dependent reaches the Plan's limiting age, as designated above. Dependent coverage does not include the spouse/domestic partner of an adult Dependent. Coverage does not include the child of an adult Dependent (grandchild) unless that grandchild meets other specified coverage criteria. 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.

NOTE: At any time, the Plan Administrator may require proof that a person qualifies, or continues to qualify, as a Dependent eligible for coverage under this Plan.

1.8 When and How to Enroll Dependents

When to Enroll Dependents

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

Partners and Dependent Children/Domestic Partner's Children" below.

How to Enroll Dependents

An Eligible Employee must:

1. Complete the enrollment process, as designated by the Plan Sponsor, for the Eligible Employee and any Eligible Dependents; and
2. Provide all information needed to determine the eligibility of the Eligible Employee and/or Dependents, if requested by Plan Sponsor.

1.9 When Dependent Coverage Begins

1. General

If a Dependent is enrolled at the same time the Participant enrolls for coverage, the Dependent's effective date of coverage will be the same as the Participant's effective date. Coverage may be applied for by contacting the Benefits Enrollment Call Center. For enrollment questions, contact your local Sanford Human Resources office.

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, benefits paid by this Plan shall be coordinated with the previous payor as outlined in Section 6, Coordination of Benefits.

3. Eligibility at Birth

If a Participant has a child through birth, the child will become a covered Dependent from the first of the month in which the child was born, if that coverage is applied for within thirty (30) days from the date of birth, and the required Premium payments are paid.

A newborn Child of a Participant is not automatically enrolled in this Plan, even if the Participant has previously elected coverage for other dependents. Participant must affirmatively enroll the newborn child. Charges for care immediately upon delivery for a newborn child will be covered under the Mother's benefit plan.

If the newborn child is not enrolled under this Plan within thirty (30) days of birth, there will be no payment by the Plan of charges attributable to the child after the mother's discharge. In such a case, subsequent enrollment of the child will be subject to "Late Enrollee" provisions as described in this SPD.

An Eligible Employee, and/or any other Dependent(s) eligible to be enrolled in the Plan, but who failed to enroll during a previous enrollment period, shall be covered under this Plan from the first of the month in which the new child was born, provided that the enrollment process is done within thirty (30) days from the date of the newborn's birth and the required Premium payments are paid. Dependent coverage is available for the Spouse/Domestic Partner, if the Spouse/Domestic Partner is otherwise eligible for coverage under the Plan, provided coverage is applied for the Spouse/Domestic Partner and, if applicable, the Participant, within thirty (30) days of the newborn's birth and the required Premium payments are paid.

4. Adoption or Children Placed for Adoption

If a Participant 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 first of the month in which the earlier of the following occur: 1) the date of adoption; or 2) beginning of the six (6) month adoption bonding period, as noted in the legal adoption papers; and provided that the enrollment process is done for the child within thirty (30) days from either 1) the date of adoption; or 2) the beginning of the six (6) month adoption bonding period and the required Premium payments are paid.

An Eligible Employee, and any other Dependent(s) eligible to be enrolled in the Plan, but who failed to enroll during a previous enrollment period, shall be covered from the first of the month in which either of the following occur: 1) the date of adoption; or 2) the beginning of the six (6) month adoption bonding period, as noted in the legal adoption papers; and provided that coverage is applied for within thirty (30) days of either 1) the date of adoption; or 2) the beginning of the six (6) month adoption bonding period, and the required Premium payments are paid.

Dependent coverage is available for the Spouse/Domestic Partner, if the Spouse/Domestic Partner is otherwise eligible

for coverage under the Plan, provided that coverage is applied for the Spouse/Domestic Partner and, if applicable, the Participant, within thirty (30) days of either 1) the date of adoption; or 2) the beginning of the six (6) month adoption bonding period, and the required Premium payments are paid.

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/Domestic Partners and Dependent Children/Domestic Partner's Children

If a Participant gets married or establishes a new domestic partnership, his or her Spouse/Domestic Partner, any of the Participant's Eligible Dependents, and any of the Spouse's/Domestic Partner's Dependents, who become Eligible Dependents as a result of the marriage/establishment of domestic partnership, will become covered as a Participant(s) from the first day of the calendar month beginning after the date of marriage/establishment of domestic partnership, provided that coverage is applied for within thirty (30) days of the date of marriage and the required Premium payments are paid.

If an Eligible Employee who does not currently have coverage under the Plan gets married or establishes a new domestic partnership, the Eligible Employee, his or her Spouse/Domestic Partner, any of the Employee's Eligible Dependents, and any of the Spouse's/Domestic Partner's Dependents who become Eligible Dependents of the Eligible Employee as a result of the marriage/establishment of domestic partnership, will become covered as Participant(s) from the first day of the calendar month beginning after the date of marriage/establishment of domestic partnership, provided that Eligibility requirements for a Dependent, listed previously in this Section 1, and coverage is applied for the Eligible Employee, and any Dependents, within thirty (30) days of the date of marriage/establishment of domestic partnership and the required Premium payments are paid.

1.10 Limitations on Qualifying for Coverage

The following are not Covered Individuals under the Plan:

1. Other individuals living in the Participant's home, but do not meet the requirements for a Dependent as previously described; or
2. The legally separated or divorced former Spouse of the Participant.
3. The ex-Domestic Partner defined by the affidavit of termination of domestic partnership.

Additionally:

1. If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during, and after the change in status, credit will be given for all Cost-Sharing Amounts.
2. If both mother and father are Participants, any children will be covered as Dependents of the mother or father, but not of both.
3. The Plan does not cover, as a Dependent, any person who is enrolled as an Eligible Employee.
4. If two Eligible Employees are married to each other or are in a domestic partnership, they may each enroll as Eligible Employees, or one of them may enroll as an Eligible Employee and the other as a Dependent of the enrolled Employee. However, one individual cannot be enrolled as both an Eligible Employee and a Dependent under this Plan.

1.11 Noncustodial Participants and Dependent Child(ren)

Whenever a Dependent Child receives coverage under the Plan through the noncustodial parent, who is the Participant, 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 a Provider/Practitioner, with the custodial parent's approval, to submit claims for Covered Services rendered to the Dependent Child(ren) without approval from the noncustodial parent; and
3. Make payment on claims for covered services submitted directly by the custodial parent or Provider/Practitioner.

1.12 Qualified Medical Child Support Order (QMCSO) Provision

Purpose

The Employee Retirement Income Security Act of 1974 (ERISA) and the Child Support Performance and Incentive Act of 1998 (CSPIA) require the Employer to take certain actions to help enforce state administrative and court orders for medical child support.

The Plan Sponsor, pursuant to the ERISA §609(a), adopts the following procedures for determining whether Medical Child Support Orders are qualified in accordance with the ERISA's requirements. Sanford also adopts these procedures to administer payments and other provisions under Qualified Medical Child Support Orders (QMCSOs), and to enforce these procedures as legally required. Sanford reserves the right to alter, amend, or terminate these procedures, and substitute alternative procedures to satisfy legal requirements.

NOTE: A state administrative order issued under CSPIA automatically is deemed qualified.

Definitions

For purposes of the QMCSO requirements, the following terms have these meanings:

1. **Alternate Recipient** means any child of a Participant who is recognized under a Medical Child Support order as having a right to enroll in a group health plan with respect to the Participant.
2. **Medical Child Support Order** means any court judgment, decree or order (including approval of settlement agreement) or state administrative order that:
 - a. Provides child support for a child of a Participant under the group health plan; or
 - b. Provides for health coverage to such a child under state domestic relations law (including a community property law); and
 - c. Relates to benefits under this Plan.
3. **Plan** means the employee medical benefit plan, including all supplements and amendments in effect.
4. **Qualified Medical Child Support Order** means a Medical Child Support Order of a court or administrative tribunal that creates or recognizes an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a participant or Beneficiary is eligible under a group health plan, and which Sanford has determined meets the qualification requirements of these procedures.
5. To be Qualified, a Medical Child Support Order must clearly:
 - a. Specify the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient covered by the order;
 - b. Include a reasonable description of the type of coverage to be provided by SHP to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and
 - c. Specify each period to which such order appliesFurthermore, to be qualified, a Medical Child Support Order must not require the Plan to provide any type or form of benefits or any option not otherwise provided under the Plan except to the extent necessary to meet the requirements described in §1908 of the Social Security Act (relating to enforcement of child support and reimbursement to Medicaid).
6. Any terms used in these QMCSO procedures and defined in the Plan shall have the meaning assigned to such term under the Plan.

Procedures

Upon receipt of a Medical Child Support Order, the Plan Sponsor shall:

1. Promptly notify in writing the Participant, each Alternate Recipient covered by the order, and each representative for these parties of the receipt of the Medical Child Support Order. Such notice shall include a copy of the order, and these QMCSO procedures for determining whether such order is a QMCSO.
2. Permit the Alternate Recipient to designate a representative to receive copies of notices sent to the Alternate Recipient regarding the Medical Child Support Order. Within a reasonable period after receiving a Medical Child Support Order, determine whether it is a Qualified Order and notify the parties as indicated in No.1 above of such determination.
3. Ensure the Alternate Recipient is treated by the Plan as a Beneficiary for ERISA reporting and disclosure purposes; e.g. by distributing to the Alternate Recipient a copy of the Summary Plan Description, Summary of Benefits and Coverage (SBC), Formulary, and any benefit plan changes, as specified in any Summary of Material Modification.

If SHP receives a state administrative or court Medical Child Support Order under CSPIA, requiring the Company to withhold

Employee contributions for group health coverage for a Child, the Plan Sponsor will determine whether the Employee is covered or eligible under the Plan, and whether the child is eligible under the Plan.

After the Plan Sponsor or Plan Administrator determines that the Employee is subject to income withholdings to pay for the child's coverage, the Plan Sponsor/Administrator will then notify the Employee, the child and the child's custodial parent (when that is not the Employee) that coverage is or will become available. The Plan Administrator will furnish the custodial parent, or legal representative of the Dependent child a description of the coverage available, the effective date of the coverage and any forms, documents or other information needed to put the coverage into effect, as well as information needed to submit claims for benefits.

The Plan Administrator/Sponsor will determine whether Employee contributions are available to pay for the child(ren)'s coverage. If such funds are available, the Employer will withhold contributions from Employee income and notify the Employee to that effect.

1.13 Special Enrollment Rights

Special enrollment rights may apply when an Employee experiences a life-changing event that qualifies them to make mid-year changes to benefit elections. Qualified Life Events are changes in an Employee's and/or an Employee's Dependent's life that affect benefit eligibility and coverage availability under the Plan.

Special enrollment rights for a qualified life event also apply when an individual becomes an Employee's Dependent through marriage/establishment of domestic partnership, birth, adoption, or placement for adoption; or when an Employee or Eligible Dependent loses other health coverage.

To enroll an Eligible Employee's new Dependent(s) under a special enrollment period, the Plan will also require the Eligible Employee to enroll. Special enrollment rights extend to all benefit packages available under the Plan.

NOTE: For qualified life events allowing special enrollment rights, Employees must contact their Human Resources – Benefits Department within thirty (30) days of the life event. Requests for Special Enrollment must be received by the Plan no later than thirty (30) days after the date of exhaustion or termination of coverage.

NOTE: If an Employee wishes to make benefit election changes after the first thirty (30) days from a qualified life event, the Employee must wait until the next annual open enrollment period.

Qualified Life Events, in accordance with IRS Regulations, include:

- The birth or adoption of a child, or your child's placement for adoption.
- Your marriage, establishment of new domestic partnership, legal separation, divorce, termination of domestic partnership, or annulment.
- The termination or beginning of your spouse/domestic partner's employment, or your dependent/ domestic partner's dependent's employment.
- You, your spouse/domestic partner's or your dependent/domestic partner's dependent's job status changes from full-time to part-time or from part-time to full-time.
- A significant change in your or your spouse/domestic partners' coverage due to your spouse/domestic partner's employment.
- Eligibility for your dependent begins or ends.
- A change in residence or work site for you, your spouse/domestic partner, or your dependent/domestic partner's dependent.
- The death of your spouse/domestic partner or dependent/domestic partner's dependent.
- Commencement or return from an unpaid leave of absence.
- Become eligible or lose eligibility for Medicaid or State Children's Health Insurance Program (SCHIP) - you have 60 days from the effective date.
- Become eligible or lose eligibility under the Federal Employee Health Benefits (FEHB) program.

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

1. **Waived Coverage.** The Eligible Employee and/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 Employee 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 Employee 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 Plan Sponsor required such a statement at such time and provided the individual with notice of such requirement at such time);*

- a. The Eligible Employee stated in writing when enrollment was available under this Plan, that coverage under a group health plan or other health insurance coverage was the reason for declining enrollment; *
2. **Exhausted COBRA.** The Eligible Employee or Eligible Dependent had previous coverage under a COBRA or state continuation provision and the coverage under such provision has now been exhausted;**Change in Employer Eligibility Rules or Employer Contributions. The Participant's previous coverage was not under COBRA, and coverage was terminated as a result of loss of eligibility for coverage, terminated for a class of similarly situated individuals, or terminated because employer contributions toward such coverage ended;
3. **A Move out of SHP's Service Area.** The Participant's previous coverage was terminated because the Participant no longer resides, lives or works in SHP's Service Area and the Plan does not provide coverage for that reason.
4. **Cessation of Dependent status.** The Participant attains an age in excess of the maximum age for coverage as a Dependent child. Requests for Special Enrollment must be received by the Plan not later than thirty-one (31) days after the date of exhaustion or termination of coverage.

You may be able to get coverage through the Health Insurance Marketplace that costs less than COBRA continuation coverage. You can learn more about the Marketplace at www.healthcare.gov. You always have 60 days from the time you lose your job-based coverage to enroll in the Marketplace.

** Loss of Minimum Essential Coverage due to failure to make premium payment and/or allowable rescissions of coverage does not qualify for special enrollment*

*** Voluntarily terminating/dropping COBRA coverage before it runs out outside Open Enrollment, does not qualify for a special enrollment period. COBRA coverage must be exhausted (usually 18 or 36 months) or another qualifying life event must occur before eligible for special enrollment. Losing COBRA coverage due to non-payment of premiums will not result in rights to a special enrollment period.*

1.14 Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA)

The Children's Health Insurance Program Reauthorization Act of 2009 grants Special Enrollment Rights to Employees and dependents who are eligible for, but not enrolled in, a group health plan to enroll in the Plan upon:

- losing eligibility for coverage under a state Medicaid or CHIP program; or
- becoming eligible for state premium assistance under Medicaid or CHIP.

In order to qualify for Special Enrollment, an Eligible Employee or Dependent must request coverage within sixty (60) days of either being: 1) terminated from Medicaid or CHIP coverage; or 2) determined to be eligible for premium assistance. The Plan will also require the Eligible Employee to enroll. Special enrollment rights extend to all benefit packages available under the Plan. If you have questions about enrolling in your employer plan under CHIPRA Special Enrollment Rights, contact the Department of Labor at www.askebsa.dol.gov or call (866) 444-3272 (toll-free).

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your state Medicaid or CHIP office or dial (877) KIDS NOW or www.insurekidsnow.gov to find out how to apply.

Section 2. How You Get Care

2.1 Identification Cards

Sanford Health Plan will send you an identification (ID) card when you enroll. Each covered Participant will receive their own Participant ID card after enrollment, which should be used when you receive care or fill a prescription. If you fail to show your ID card at the time you receive Health Care Services or prescription drugs, you will be responsible for payment of the claim after the In-Network Participating Practitioner and/or Provider's timely filing period of one-hundred-eighty (180) 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.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, please contact us or log in to the Participant Portal to request a new one at sanfordhealthplan.com/memberlogin.

2.2 Conditions for Coverage

This Plan does not pay all medical expenses. It pays certain expenses under certain circumstances.

Participants are entitled to coverage for the Health Care Services (See "Covered Services" in Section 3) that are:

1. Medically Necessary, and/or Preventive, services within the scope of health care benefits covered by this Plan received from or provided under the orders or direction of an In-Network Participating Practitioner and/or Provider; or
2. Services otherwise authorized by Sanford Health Plan.

However, this specific condition does not apply to Emergency Condition, as defined in Section 11. In such cases, Emergency or Urgent Care services will be covered if they are provided by a Non-Participating Provider or an Out-of-Network Participating Provider. Services must meet Prudent Layperson definitions, as described later in this Summary Plan Document.

If during an Emergency Condition, the Participant is in the Plan's Service Area and is alert, oriented and able to communicate (as documented in medical records), the Participant must direct the ambulance to the nearest In-Network Participating Practitioner and/or Provider.

The Covered Individual must pay any applicable Cost-Sharing Amounts.

NOTE: Just because a Health Care Provider recommends, or prescribes, a course of treatment does not mean that the Plan will pay the cost.

Designating a Practitioner and/or Provider

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

Participants have the right to designate any PCP who participates in the Plan network and who is available to accept the Participant. For information on how to select a PCP, and for a list of the Participating PCP's, contact Customer Service or visit www.sanfordhealthplan.com. For children, you may designate a pediatrician as their PCP. Participants who are female do not need prior authorization from the Plan, or from any other person (including a PCP), in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Customer Service, or visit www.sanfordhealthplan.com.

In addition, all Health Care Services are subject to:

The exclusions and limitations described in Sections 3 and 4; and

Any applicable Copay, Deductible, and Coinsurance amount as stated in this SPD; your Summary of Benefits and Coverage.

2.3 In-Network Coverage

There are two (2) levels of coverage available:

1. In-Network Coverage; and

2. Out-of-Network Coverage.

NOTE: This Plan does not cover most Out-of-Network services. *For Out-of-Network coverage, please see Section 3.7.*

In-Network Coverage means Covered Services that are received:

1. from an In-Network Participating Practitioner and/or Provider; or
2. from a Participating Practitioner and/or Provider if an In-Network Participating Provider and/or Provider has recommended the referral and Sanford Health Plan has authorized the referral to a Participating Practitioner and/or Provider ;or
3. when experiencing an Emergency Medical Condition or in an Urgent Care Situation; or
4. from a Non-Participating Practitioner and/or Provider when all appropriate In-Network Participating Practitioner and/or Provider options have been exhausted and Sanford Health Plan has authorized the service.

NOTE: If you choose to go to a Non-Participating Practitioner and/or Provider or an Out-of-Network Participating Practitioner and/or Provider when access to an In-Network Participating Practitioner and/or Provider is available, your claims will be denied and you will be responsible for all charges.

2.4 Appropriate Provider Access

Primary Care Practitioners and Hospital Providers

Appropriate access for In-Network Participating Practitioners and/or Providers for Primary Care Services, Mental Health, Substance Use Disorder Treatment, and Hospital is within *thirty (30)* miles of a Participant's legal residence.

Specialty Practitioners and Providers

For other Participating Practitioners and Providers such as Specialty Practitioners, Diagnostic Service Centers, Nursing Homes, and Rehabilitation Providers, appropriate is determined by a variety of considerations including but not limited to specialty, level of care, wait time, quality of care, distance, and unique case distinctions. For these reasons, requests to go anywhere other than an In-Network Participating Provider must be authorized by Sanford Health Plan.

Transplant Services

Transplant Services must be performed at designated Plan Participating *Centers of Excellence*. 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.

Pharmacy/Prescription Drug Services

Prescription medications, drugs, and/or devices must be dispensed by an In-Network Pharmacy Provider. There is no coverage for these services received Out-of-Network. For benefit details, see Section 3.5 and/or your SBC.

Coverage Outside of Service Area

Participants who live outside of the Plan's Service Area must use the Plan's contracted Network of Participating Providers as indicated on the Member Identification Card and on the Provider Directory. Participants who live outside the Service Area will receive Identification Cards that display their network logo along with instructions on how to access Participating Providers. If a Participant chooses to go to a Non-Participating or Out-of-Network Practitioner or Provider when appropriate access is available, claims will be processed at the Out-of-Network coverage level.

Sanford Health Plan reserves the right to review each individual's unique situation on a case-by-case basis to evaluate factors such as access to care, medical conditions, and geographic situations to determine if an Out-of-Network or Non-Participating Provider qualifies to be covered at an In-Network coverage level.

2.5 Participant Process for Seeking Urgent/Emergency (Urgent Pre-service) Medical Care

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.

Emergency admissions to a hospital do not require you to file a pre-service claim so long as your Practitioner and/or Provider provide notice to us within forty-eight (48) hours of the admission, and we certify the admission as both medically necessary and as an emergency admission. Additionally, because of the inability to predict admission, obstetrical admissions are encouraged to be certified when the pregnancy is confirmed. The exception is that of an elective C-section, which must be certified as an elective admission.

An **Urgent Care Situation** is a degree of illness or injury, which is less severe than an Emergency Medical Condition, but requires prompt medical attention within twenty-four (24) hours, such as stitches for a cut finger.

If an Urgent Care Situation occurs, Participants should contact their Primary Care Practitioner and/or Provider (PCP) immediately, if one has been selected, and follow his or her instructions. Prior Authorization is not required for an Urgent Care Situation or Emergency Medical Condition. A Participant may always go directly to an In-Network urgent care or after-hours clinic.

2.6 Determination and Review Process – OVERVIEW

Your Complaint (Grievance) & Appeal Rights

If you are dissatisfied with our handling of a claim or have any questions or complaints, you may do one or more of the following:

You may call or write Customer Service or the Appeals and Grievances Department. We will help you with questions about your coverage and benefits or investigate any adverse benefit determination you might have received; or

You may file an Appeal if you have received an Adverse Benefit Determination. Please see Section 10 for more information on the Appeals Process.

The Plan's claims procedures are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA). Because this Plan is subject to ERISA, we will process your claim according to ERISA standards and provide you with ERISA appeal rights. In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), criteria for medical necessity determinations is available upon request to any current or potential participant, beneficiary, or contracting provider.

Designating an Authorized Representative

You may act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this subsection. An Authorized Representative is someone you designate in writing to act on your behalf. We have developed a form that you must complete if you wish to designate an Authorized Representative. You can get the form by calling Customer Service. You can also log into your account at www.sanfordhealthplan.com/memberlogin and download a copy of the form. If a person is not properly designated as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this subsection of your SPD. For urgent pre-service claims, we will presume that your Provider is your Authorized Representative unless you tell us otherwise in writing.

Your Right To Information

You have the right, upon request, to receive copies of any documents that we relied on in reaching our decision and any documents that were submitted, considered, or generated by us in the course of reaching our decision. You also have the right to receive copies of any internal rules, guidelines, or protocols that we may have relied upon in reaching our decision. If our decision was based on a medical or scientific determination (such as medical necessity), you may also request that we provide you with a statement explaining our application of those medical and scientific principles to you. If we obtained advice from a health care professional (regardless of whether we relied on that

advice), you may request that we give you the name of that person. Reasons for any denial or reimbursement or payment for services with respect to benefits under the Plan will be provided within 30 business days of a request. We will not charge you for any information that you request regarding our decision.

Adverse Determinations

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 Participant can request to Appeal an Adverse Determination. Refer to "Problem Resolution" in Section 10 for details.

Benefit Determination Process

Sanford Health Plan Appeals and Grievances Department reviews all non-medical benefit determinations through review of SPD language, contractual terms, administrative policies related to benefits as defined by this Policy, and benefits requests. All benefit determinations that are Adverse will be made by the person assigned to coordinate Benefit, Denial, and Appeal processes.

The date of receipt for non-urgent (standard) requests received outside of normal business hours will be the next business day.

Refer to the Summary Notice and Important Information section in the beginning of this document for instructions on how to contact the Appeals and Grievances department.

2.7 Routine (Non-Urgent) Pre-Service Benefit Requests

All pre-service benefit determination (approval) requests will be determined within fifteen (15) business days of receipt of the request. When a preauthorization (pre-approval) request is received before a service occurs, the date of receipt for non-urgent (standard) requests is the date the Plan receives the Participant's request. If the request is made outside of business hours, the date of receipt will be next business day. If Sanford Health Plan denies a benefit (an Adverse Benefit Determination) the Plan will contact the Practitioner and/or Provider and Participant via mail.

2.8 Routine Post-Service Benefit Requests

Retrospective (post-service) requests occur when a Participant has already utilized healthcare services and the Practitioner and/or Provider did not inquire about coverage pre-service. Additionally, post-service requests are not related documentation, coding or reimbursement from the Plan. Sanford Health Plan will review and approve or deny the service based on Medical Necessity within thirty (30) calendar days of receipt of the request. A letter will be sent to the Practitioner and/or Provider and Participant within those 30 calendar days with the Plan's determination.

Utilization Management Review Process

Refer to the Summary Notice and Important Information section at the beginning of this document for instructions on how to contact the Utilization Management Department.

The date of receipt for non-urgent (standard) 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 SHP Chief Medical Officer, designee, or appropriate Practitioner. Claims for benefits under the Plan can be post-service, pre-service, or concurrent. This subsection explains how we process different types of claims.

2.9 Prospective (Pre-service) Review of Services (Certification/Prior Authorization)

Prior Authorization (also referred to as Certification) is a decision by the Plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary and appropriate. Preauthorization is required for services as defined above, except in urgent or emergent situations. Although the Plan may authorize a health care service as medically necessary, it is not a guarantee the Plan will cover the cost.

Determination of the appropriateness of care is based on standard review criteria and assessment of the following factors:

1. The Participant's medical information, including diagnosis, medical history and the presence of complications and/or comorbidities.
2. Consultation with the treating Practitioner and/or Provider, as appropriate.
3. Availability of resources and alternate modes of treatment. For admissions to Facilities, other than Hospitals, additional information may include but is not limited to history of present illness, patient treatment plan and goals, prognosis, staff qualifications and twenty-four (24) hour availability of qualified medical staff.

Sanford Health Plan does not compensate Practitioners, Providers or other individuals conducting Utilization Review for

issuing denials of coverage or service care. Any financial incentives offered to Utilization Review decision makers do not encourage decisions that result in underutilization and do not encourage denials of coverage or service.

NOTE: Only Emergency and/or Urgent Care Services are covered at the In-Network level when provided by an Out-of-Network or Non-Participating Practitioner or Provider. There is no coverage for any other health care service received from an Out-of-Network Participating Practitioner and/or Provider or a Non-Participating Practitioner and/or Provider.

Prior Authorization is not a Guarantee of Benefits. All Plan terms and exclusions still apply and may result in a denial of benefits.

NOTE: Prior Authorization is the responsibility of your Practitioner and/or Provider. For an up-to-date list or more information on all things that require prior authorization, please visit www.sanfordhealthplan.org/members/prior-authorization.

2.10 Urgent/Emergency Care Request Defined

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

1. Could seriously jeopardize the life or health of the Participant or the ability of the Participant 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 Participant's medical condition, would subject the Participant 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," SHP shall apply the judgment of a Prudent Layperson, as defined in Section 11. A Practitioner, with knowledge of the Participant's medical condition, who determines a request to be "Urgent" as defined in Section 11, shall have such a request treated as an Urgent Care Request.

2.11 Pharmaceutical Review Requests and Exception to the Formulary Process

For any request of: 1) a Non-Covered medication or drug; or 2) a medication, or drug not currently listed in the SHP Formulary, the Plan follows the following process:

1. The Practitioner, Participant, or Participant's Authorized Representative, shall initiate contact with Pharmacy Management via a phone call, email, online fillable form submission, or letter of medical necessity requesting coverage for the specific medication or drug.
2. SHP will review the request based on medical necessity criteria.
3. As needed, medical records showing trial and failure of a formulary drug, or reasons why a formulary drug trial should be bypassed, will be requested.
4. Additional clinical information such as diagnosis, drug fill history, and course of disease progression, may also be requested to make a determination.
5. If the reason for the exception request is not clear, SHP will contact the prescribing provider/practitioner to discuss the case.
6. If needed, a clinical consultant of the appropriate specialty may be consulted for review.
7. SHP will use appropriate practitioners to consider exception requests and promptly grant an exception to the drug formulary, including exceptions for anti-psychotic and other drugs to treat mental health conditions, for a Participant when the practitioner prescribing the drug indicates to SHP that:
 - a. the formulary drug causes an adverse reaction in the patient;
 - b. the formulary drug is contraindicated for the patient; or
 - c. the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

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

8. If the decision is to approve the request, and the request is a standard exception request, the Plan will provide coverage of the non-formulary drug for the duration of the prescription, including refills. If the request is granted and the exception is based on exigent circumstances, the Plan will provide coverage for the duration of the exigency.
9. Standard requests for an exception to the formulary will be determined within a reasonable period of time appropriate to

the covered person's medical condition, but in no event later than fifteen days after the date the health carrier receives the request.

10. For Expedited (Urgent) requests for an exception to the formulary, a determination will be made as soon as possible, but no later than *seventy-two (72) hours* after the Plan receives the initial request. The Plan will communicate to the Participant and provider will be provided a reason for the denial and the request is a Standard Exception Request, standard appeal rights will be provided and the Participant, applicable Provider(s) and/or Practitioner(s), and if applicable, the Participant's Authorized Representative, will be notified by phone and in writing. At this point, the Participant has the right to request an Appeal of Adverse Determination shall provide written notice in accordance with the *Written Notification Process for Adverse Determinations* procedure below. At this point, the Participant can request an Appeal of Adverse Determination. For more information, see Section 10.

2.12 Prospective (Non-urgent Pre-service) Review Process for Elective Inpatient Hospitalizations and Non- Urgent Medical Care

All requests for prior authorization (Certification) are to be made by the Practitioner and/or Providers office at least *three (3)* business days prior to the scheduled admission or requested service. Utilization Management will review the Practitioner and/or Providers medical request against standard criteria. In order to file a request for prior authorization (Certification) your provider must call our Utilization Management Department. **Prior Authorization is not a Guarantee of Benefits. All Plan terms and exclusions still apply and may result in a denial of benefits.**

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

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

For Medical Necessity Requests

Utilization Management will review the Participant's profile information against standard criteria. A determination for elective inpatient or non-urgent care will be made by Utilization Management within fifteen (15) calendar days of receipt of the request. If Utilization Management is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fifteen (15) calendar days. Within fifteen (15) calendar days of the request for authorization (Certification), SHP must notify the Participant or Participant's Authorized Representative and the Practitioner and/or Providers of the need for an extension and the date by which it expects to make a decision.

Lack of Necessary Information

If SHP is unable to make a decision *due to lack of necessary information*, it must notify the Participant or the Participant's Authorized Representative and the Practitioner and/or Providers of what specific information is necessary to make the decision within fifteen (15) calendar days of the Prospective (Pre- service) Review request. SHP must give the Practitioner and/or Providers a reasonable amount of time taking into account the circumstances, but not less than forty-five (45) calendar days to provide the specified information. In addition to notifying the Participant, SHP will notify the Practitioner and/or Provider of the information needed. The Prospective (pre-service) Review determination shall either be Prior Authorization of the requested service or additional review will be needed by SHP's Chief Medical Officer or designee, 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, SHP will deny the request.

If SHP receives a request that fails to meet the procedures for prospective review requests, SHP will notify the Practitioner and/or

Provider and Participant 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. SHP will give oral and/or written notification to the Participant, Practitioner and those Providers involved in the requested service.

Timeframe Extensions

If Utilization Management is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fifteen (15) calendar days. SHP 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, by the end of the timeframe given to provide information) to the Participant and the Practitioner and/or Providers.

Adverse Determinations

If SHP's determination is an Adverse Determination, SHP shall provide written notice in accordance with the Written Notification Process for Adverse Determinations procedure below. At this point, the Participant can request an appeal of Adverse Determinations. Refer to "Problem Resolution" in Section 10 for details.

2.13 Concurrent Review Process for Medical Care Requests

Concurrent Review is utilized when a request for an extension of an approved ongoing course of treatment for medical care, including care for behavioral, mental health, and/or substance use disorders, 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.

Determinations by us to Limit or Reduce Previously Approved Care

If we have previously approved a hospital stay or course of treatment to be provided over a period of time or number of treatments, and we later decide to limit or reduce the previously approved stay or course of treatment, we will give your Practitioner and/or Providers and you advance written notice to permit you to initiate an appeal and obtain a decision before the date on which care or treatments are no longer approved. You must follow the rules we establish for the filing of your appeal, such as the time limits within which the appeal must be filed (See Section 10 for more information on the Appeals Process). Benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow you to appeal and obtain a review determination before the benefit is reduced or terminated. In addition, individuals in urgent care situations and those receiving an ongoing course of treatment may proceed with expedited external review at the same time as the internal appeals process.

Prior Authorization (Certification) of inpatient care stays will terminate on the date the Participant is to be discharged from the Hospital or other Facility (as ordered by the attending Physician), or when the Participant's coverage is terminated. 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 are non-covered.

Requests by Your Practitioner and/or Providers to Extend Previously Approved Care

A Practitioner and/or Providers who is requesting an extension of an approved ongoing course of treatment beyond the ordered period of time or number of treatments must request Prior Authorization from SHP at least *twenty-four (24) hours* in advance of the termination of such continuing services. Your Practitioner and/or Providers may make this request in writing or orally directly to us. To request a concurrent review determination, call Utilization Management.

If Utilization Management denies the extension of treatment, it will advise the Participant and Practitioners and/or Providers within twenty- four (24) hours of receiving the request. If the Participant decides to appeal this denial, the health care services or treatment subject to the Adverse Determination shall be continued without cost to the Participant while the determination is under review as specified by the Appeal procedures outlined in Section 10.

If the internal review process results in a denial of the request for an extension, the payment of benefits for such treatment shall terminate but the Participant may pursue the appeal rights described in Section 10.

Any reduction or termination by the Plan during the course of treatment before the end of the period or number of 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, SHP shall make a determination and orally notify the Participant, or the Participant's Authorized Representative, Practitioner and those Providers

involved in the provision of the service, of the determination as soon as possible, taking into account the Participant's medical condition, but in no event more than twenty- four (24) hours after the date of SHP's receipt of the request.

SHP will provide electronic or written notification of an authorization to the Participant, Practitioner and those Providers involved in the provision of the service within three (3) calendar days after the oral notification.

SHP shall provide written or electronic notification of the Adverse Determination to the Participant 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 Participant or, the Participant'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. SHP will terminate payment of benefits on the date that oral notification of the reduction or termination of benefits is made. In cases where the Participant is not at financial risk, Participants will not be notified of an Adverse Determination unless the decision has the potential to adversely affect the Participant, in terms of coverage or financially, whether immediate or in the future.

Non-Urgent (Standard) Concurrent Reviews

If your request is non-urgent, we will treat it as a new claim for benefits and will make a determination on your claim within the pre-service or post-service timeframes as outlined in this Section.

Urgent Concurrent Reviews

If your Practitioner and/or Providers request for additional care is urgent, and if your Practitioner and/or Providers submits it no later than twenty-four (24) hours before the end of your pre-approved stay or course of treatment, SHP will make the decision as soon as possible (taking into account the medical exigencies) but no later than twenty- four (24) hours after receiving the request. For authorizations and denials, SHP will give telephone notification of the decision to Participants, Practitioners, and those Providers involved in the provision of the service within twenty-four (24) hours of receipt of the request. SHP will give oral, written or electronic notification of the decision to the Participant, 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 oral notification.

If your Practitioner and/or Providers attempt to file an urgent concurrent review but fails to follow our procedures for doing so, we will notify you and the Practitioner and/or Providers of the failure within twenty-four (24) hours. Our notification may be oral, unless asked for in writing.

Adverse Determinations

If SHP's determination is an Adverse Determination, SHP shall provide written notice in accordance with the Written Notification Process for Adverse Determinations procedures outlined below. At this point, the Participant can request an appeal of Adverse Determinations. Refer to the "Appeal Procedures" in Section 10 for details.

Lack of Necessary Information

If we need more information, we will let your Practitioner and/or Providers know within twenty (24) hours of your claim. SHP will tell your Practitioner and/or Providers what further information is needed. Your Practitioner and/or Providers will then have forty-eight (48) hours to provide us with the additional information. SHP will notify you and your Practitioner and/or Providers of our decision within forty-eight (48) hours after we receive all requested information. Our notification may be oral; if it is, we will follow it up in writing within three (3) days. If we do not receive the information, your claim will be considered denied at the expiration of the forty-eight (48) hours we gave your Practitioner and/or Providers for furnishing the information to us.

2.14 Retrospective (Standard/Non-Urgent) Review Process for Medical Care Requests

Retrospective (Post-service) Review is used by Sanford Health Plan to review services that have already been utilized by the Participant where such services have not involved a pre-service claim, and where the review is not limited to the veracity of documentation, accuracy of coding, or adjudication for payment.

Sanford Health 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 Practitioner and/or Providers and Participant within thirty (30) calendar days of receipt of the request. If Utilization Management is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fifteen (15) calendar days. Within thirty (30) calendar days of the request for review, Sanford Health Plan will notify the Participant or Participant's Authorized Representative and Practitioner and/or Providers of the need for an extension and the date by which it expects to make a decision.

Written Notification Process for Adverse Medical Care and/or Benefit Determinations

The written notification for an Adverse Determination will include the following:

1. The specific reason for the Adverse Determination in easily understandable language.
2. Reference to the specific internal Plan rule, guideline, or protocol on which the determination was based and notification that the Participant will be provided a copy of the actual Plan provisions, guidelines, and protocols free of charge upon request. Reasons for any denial or reimbursement or payment for services with respect to benefits under the Plan will be provided within 30 days of a request.
3. If the Adverse Determination is regarding coverage for a mental health and/or substance use disorder, a statement notifying Participants of their opportunity to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not be (and is not) considered a request for an internal appeal or external review.
4. If the Adverse Determination is based in whole or in part upon the Participant failing to submit necessary information, the notice shall include a description of any additional material or information, which the Participant failed to provide to support the request, including an explanation of why the material is necessary.
5. If the Adverse Determination is based on medical necessity or an 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 Participant's medical circumstances, or a statement that an explanation will be provided to the Participant free of charge upon request.
6. For Mental Health and/or Substance Use Disorder (MH/SUD) Adverse Determinations, if information on any medical necessity criteria is requested, documents will be provided for both MH/SUD and medical/surgical benefits within 30 days of a Participant/Authorized Representative/Provider's request. This information will include documentation of processes, strategies, evidentiary standards and other factors used by the Plan, in compliance with MHPAEA.
7. If the Adverse Determination is based on medical necessity, a written statement of clinical rationale, including clinical review criteria used to make the decision if applicable. If the denial is due to a lack of clinical information, a reference to the clinical criteria that have not been met will be included in the letter. If there is insufficient clinical information to reference a specific clinical practice guideline or policy, the letter will state the inability to reference the specific criteria and will describe the information needed to render a decision.
8. A description of SHP's Appeal procedures, including how to obtain an expedited review if necessary (and any time limits applicable to those procedures) including:
 - a. a Participant's right to bring civil action under §502(a) of ERISA;
 - b. the right to submit written comments, documents or other information relevant to the appeal;
 - c. an explanation of the Appeal process including the right to Participant representation;
 - d. notification that Expedited External Review can occur concurrently with the internal Appeal process for urgent care/ongoing treatment; and
 - e. the timeframe the Participant has to make an appeal and the amount of time the Plan has to decide it (including the different timeframes for Expedited Appeals).
9. If the Adverse Determination is based on medical necessity, notification and instructions on how the Practitioner can contact the Physician or appropriate Practitioner to discuss the determination.

Section 3. Covered Services – OVERVIEW

3.1 Medical Services & Supplies Provided by Physicians and Other Health Care Professionals

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

- All benefits for authorized services are subject to the definitions, limitations, and exclusions in this Summary Plan Description and are payable only when they are Medically Necessary.
- Benefits will be denied if the Member is not eligible for coverage under this benefit plan on the date services are provided.
- Be sure to read Section 2, *How You Get Care*, for valuable information about conditions for coverage.
- Your Practitioner and/or Provider must get Prior Authorization of some services in this Section. Receipt of Certification (Prior Authorization) does not guarantee payment of benefits. The benefit description will say "Prior Authorization (Certification) is required; failure to get Prior Authorization will result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

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Allergy Care Benefit

Allergy care coverage includes testing and treatment, allergy injections, and allergy serum.

NOT COVERED:

- Air conditioners, air filters, or other products to eradicate dust mites
- Any form of allergy testing and immunotherapy that is considered experimental or not FDA approved
- Chiropractic manipulations for allergies
- Diet therapy (specialty foods) for allergies
- Duplicate services, including allergy testing for percutaneous scratch tests, intradermal tests, and patch tests
- Homeopathic treatment of allergies
- Provocative food testing
- Sublingual allergy desensitization

Amino Acid-based Elemental Oral Formulas Benefit

Amino acid-based elemental oral formula coverage includes medical foods and low-protein modified food products determined by a Practitioner and/or Provider to be medically necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.

NOT COVERED:

- Dietary desserts and snack items
- Low protein modified food products or medical food for PKU to the extent those benefits are available under a government program that provides coverage for the same

Artificial Nutrition benefit

⚠ Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

Artificial Nutrition coverage includes parenteral nutrition formula and supplies, and enteral nutrition formula and supplies. Coverage is subject to Sanford Health Plan Guidelines.

NOT COVERED:

- Formula and supplements available Over the Counter

Cardiac Rehabilitation Therapy

Therapy coverage includes: Cardiac rehabilitation delivered as part of an inpatient hospitalization. Outpatient cardiac rehabilitation is a covered benefit when referred by a physician and provided under the general supervision of a physician (limited to 36 visits per calendar year)

NOT COVERED:

- *Maintenance Therapy*

Chiropractic Services Benefit

Chiropractic services coverage includes 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:

- *Hot/cold pack therapy, including polar ice therapy and water circulating devices*
- *Therabands and cervical pillows*
- *Traction services in the home*
- *Vitamins and minerals (unless otherwise specified as covered in this Policy)*

Diabetes Supplies, Equipment, and Education Services Benefit

Diabetes care and education includes:

- Routine foot care, including toenail trimming is covered.
- Diabetes self-management training and education shall only 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.

 Indicated Durable Medical Equipment (DME) requires Prior Authorization (Certification); failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

Diabetes supplies and equipment coverage includes:

Item	Information
Blood glucose test strips, Glucagon, glucometers, glucose agents, lancets and lancet devices, prescribed oral agents for controlling blood sugars, syringes, urine testing strips	Must be obtained at: Pharmacy (prescription required) Benefit/Cost information: Pharmacy Benefit; deductible/coinsurance may apply
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 three (3) additional pairs of inserts	Must be obtained at: Durable Medicare provider Benefit/Cost information: Medical Benefit; deductible/coinsurance will apply
Continuous Glucose Monitor (CGM)	Certification may be required Must be obtained at: Durable Medical Provider and/or Pharmacy (prescription required) Benefit/Cost information: Pharmacy Benefit (must be on formulary and available through a pharmacy) or Medical Benefit (if obtained through a Durable Medical Provider); deductible/coinsurance may apply

Item	Information
Insulin Pump	Certification may be required Must be obtained at: Durable Medical Provider and/or Pharmacy (prescription required) Benefit/Cost information: Medical Benefit; deductible/coinsurance will apply

NOT COVERED:

- Food items for medical nutrition therapy

Diagnostic and treatment services

Professional services from Physicians, nurse practitioners, and Physician's assistants are covered when provided in a Physician's office, an urgent care center, medical office consultations, electronic-consults/telehealth, and second surgical opinions.

Dialysis

Dialysis for renal disease services include equipment, training, and medical supplies required for effective dialysis care. Coordination of Benefit (COB) Provisions apply. For more information on COB, please see Section 6.

NOT COVERED:

- Wearable artificial kidney, each

Durable medical equipment (DME) benefit

Durable medical equipment (DME) coverage is as follows:

- Coverage for DME equipment prescribed by an attending Practitioner and/or Provider, 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.
- Coverage includes DME equipment for habilitative services per Medical Necessity.
- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Sanford Health Plan policy.

DME Requiring Prior Authorization

 Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

- Airway Clearance Device
- Beds such as Hospital beds and mattresses
- Communication Device
- Equipment that has a cost greater than or equal to \$10,000.00
- Insulin Pump
- Phototherapy UVB Light Device
- Pneumatic Compression with external pump
- Prosthetic Limb
- Selected Orthotics

NOT COVERED:

- Any other equipment and supplies which SHP determines is not eligible for coverage
- Commodes and/or similar convenience items
- Communication aids or devices to create, replace or augment communication abilities including, but not limited to, hearing aids (unless otherwise specified as covered in this SPD), speech processors, receivers, communication boards, or computer or electronic assisted communication
- Coverage is limited to one (1) piece of same-use equipment (e.g. mobilization, suction), unless replacement is covered under the replacement guidelines in this policy. Duplicate or back up equipment is not a covered benefit.

- *Deluxe equipment*
- *Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage*
- *Duplicate or similar items*
- *First aid or precautionary equipment such as standby portable oxygen units*
- *Home Modifications including but not limited to wiring, plumbing or changes for installation of equipment*
- *Home Traction Units*
- *Household equipment whose primary use is customarily non-medical, including 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*
- *Items which are primarily non-medical and educational in nature or for vocation, comfort, convenience or recreation*
- *Maintenance and service fee for capped-rental items*
- *Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliances*
- *Remote control devices as optional accessories*
- *Replacement or repair of equipment if items are lost or stolen; or damaged or destroyed by Participant misuse, abuse, or carelessness*
- *Revision of durable medical equipment, except when made necessary by normal wear or use*
- *Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates*
- *Self-help and adaptive aids are not a covered benefit, including assistive communication devices and training aids.*
- *Upgrades of equipment for outdoor use, or equipment needed for use outside of the home that is not needed for in-home use, are not covered.*
- *Vehicle modifications including but not limited to hand brakes, hydraulic lifts, and car carriers*

Eye Care and Vision Services

Eye Care coverage is as follows:

Exams and Services	Child (age 0-18)	Adult (age 19+)
Services required because of injury, accident or cancer that damages the eye	Covered if the Participant was covered under this Contract during the time of the injury or illness causing the damage	Covered if the Participant was covered under this Contract during the time of the injury or illness causing the damage
Dilated eye examination for diabetes-related diagnosis	Covered with a limit of one exam per Participants per benefit period	Covered with a limit of one exam per Participants per benefit period
Vision therapy	Covered	Covered
Routine eye exam	Not covered unless otherwise specified	Not covered unless otherwise specified
Cataract surgery	Covered	Covered
Eye Wear (frames, lenses, contacts)	Child (age 0-18)	Adult (age 19+)
<u>Aphakia patients</u> : Eyeglasses or contact lenses or soft contact lenses	One (1) pair of eyeglasses, including lenses and frame per lifetime; or Two (2) single clear contact lenses per Participant per benefit period	One (1) pair of eyeglasses, including lenses and frame per lifetime; or Two (2) single clear contact lenses per Participant per benefit period
Scleral shells intended for the use in the treatment of a disease or injury	Soft shells limited to two (2) per calendar year; Hard shells limited to one (1) per lifetime	Soft shells limited to two (2) per calendar year; Hard shells limited to one (1) per lifetime
<u>Cataract surgery patients</u> : Prescribed lenses and frames	Not covered	Not covered
Prescribed lenses and frames, unless otherwise listed the plan documents	Not covered	Not covered

NOT COVERED:

- Additional refractive procedure (including lens) after coverage of initial lens at time of cataract correction.
- Lasik eye surgery
- Radial Keratotomy, Myopic Keratomileusis, and any surgery involving corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error
- Refractive errors of the eye
- Replacement of lost, stolen, broken, or damaged lenses or glasses
- Routine cleaning of Scleral Shells
- Special lens coating or lens treatments for prosthetic eyewear

Family Planning

Family planning coverage is as follows:

- Consultations and pre-pregnancy planning.
- Participant education and counseling, as prescribed by a health care provider for women with reproductive capacity.
- Voluntary Sterilizations, including tubal ligations and vasectomies. Applicable cost sharing may apply; see contraceptive coverage covered without cost-sharing below.
- Folic acid supplements are covered at 100% (no cost) for women planning to become pregnant or in their childbearing years.

Sanford Health Plan covers, without cost-sharing, at least one form of contraception in each of the eighteen (18) methods below that the FDA has identified for women in its current Birth Control Guide. These methods fall into three (3) categories.

1. Obtained during an office visit/medical procedure:
 - a. Surgical sterilization implant/occlusion of the fallopian tubes by use of permanent implants
 - b. Sterilization surgery/tubal ligation covered at 100% only when performed as the primary procedure
 - c. Implantable devices (Placement and removal is covered per device guidelines or as Medically Necessary).
Includes
 - i. Implantable rod.
 - ii. IUD Copper
 - iii. IUD Progestin
 - d. Shot/Injection: includes injectable medroxyprogesterone acetate
 - e. Cervical Cap.
2. Obtained with a prescription:
 - a. Oral Contraceptives/Combined pill
 - b. Oral Contraceptives/Progestin only
 - c. Oral Contraceptives/Extended Continuous
 - d. Patch
 - e. Vaginal Contraceptive Ring
 - f. Emergency contraception
3. Available over the counter (OTC) :(For OTC contraception, a written prescription order must be provided for Sanford Health Plan to cover at 100% (no charge), even though no prescription order is required for the OTC purchase of the drug and/or supply)
 - a. Sponge
 - b. Barrier methods: includes Diaphragm and cervical cap fitting and purchase.
 - c. Female Condom
 - d. Spermicide (generic only)

Sanford Health Plan will continue to utilize reasonable medical management techniques, and impose cost sharing on some items and services to encourage Participants to use specific items and services within the chosen contraceptive method.

Formulary generic contraceptives are covered at 100% (no charge), regardless of how the contraceptive is delivered or dispensed. This coverage includes but is not limited to oral contraceptives.

If no generic equivalent exists for a Formulary brand-name contraceptive, then that contraceptive is covered at 100% (no

cost) per the Affordable Care Act, for the length of the prescription.

NOTE: For Participants enrolled in a High Deductible Health Plan, prescription drugs are subject to Deductible and Coinsurance amounts, unless the medication or drug dispensed is covered by the Contract at 100% (no charge).

NOT COVERED:

- Any expenses related to surrogate parenting, except if Surrogate is a covered Participant under this SPD and seeking otherwise Covered Services
- Elective abortion services except when the mother's life is endangered. Prior Authorization/certification required.
- Reversal of voluntary sterilization

Foot Care Benefits

Routine foot care covered for Participants when medically appropriate. See *Orthotic and prosthetic devices* in this Section for information on podiatric shoe inserts.

NOT COVERED:

- Treatment of weak, strained, or flat feet

Hearing Testing, Treatment, and Supplies

Hearing services coverage is as follows:

Exams and Services	Child (age 0-18)	Adult (age 19+)
Annual routine hearing exam	Not covered	Not covered
Emergency and acute hearing services	Covered	Covered
Diagnosis and treatment of sudden sensorineural hearing loss (SSNHL)	Covered	Covered
Hearing Devices	Child (age 0-18)	Adult (age 19+)
⚠ Prior Authorization (Certification) may be required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization		
Cochlear implants and bone-anchored (hearing-aid) implants	Prior Authorization (Certification) required	Prior Authorization (Certification) required
External Hearing Aids or devices	Hearing aids, communication aids or devices for Participants 18 years of age or younger for hearing loss that is not correctable by other covered procedures. Sanford Health Plan policy guidelines apply.	External hearing aids when medically necessary for conditions including, but not limited to: sudden sensorineural hearing loss (SSNHL), accident, injury or related illness.*
Hearing aid limits	Benefit is limited to one hearing aid, per ear, per Participant under 19, every three (3) years, in alignment with Medical Necessity and Sanford Health Plan guidelines	Benefit is limited to one hearing aid, per ear, per Adult Participant, every five (5) years, in alignment with Medical Necessity and Sanford Health Plan guidelines This is a DME that requires Prior Authorization (Certification)

* The provision of hearing aids must meet criteria for rehabilitative and/or habilitative services coverage and either:

- provide significant improvement to the Member within two (2) months, as certified on a prospective and timely basis by Sanford Health Plan; or
- help maintain or prevent deterioration in physical, cognitive, or behavioral function.

NOT COVERED:

- All other hearing related supplies, purchases, examinations, testing or fittings unless otherwise specified as covered
- Tinnitus Maskers

Home Health Services

 Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

Participant must be homebound to receive home health services.

The following Home Health Services are covered in lieu of an inpatient stay, if approved (certified) by SHP:

- Part-time or intermittent skilled 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 Plan benefit.
- Medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Participant were Hospital
- Limited to 40 visits in a calendar year and does not include meals, custodial care or housekeeping
- Skilled behavioral health services

As skilled nursing or home health aide visit is defined as a visit of up to a consecutive 4-hour period of time in duration. A behavioral health visit is defined as a visit of up to 1 hour in duration.

NOT COVERED:

- Charges for meals or housekeeping
- Custodial or convalescent care
- Long-term residential care
- Maintenance care
- Nursing care requested by, or for the convenience of the patient or the patient's family (rest cures)
- Private-Duty Nursing

Implants/Stimulators

Implants and Stimulators prescribed by an attending Practitioner and/or Provider and are Medically Necessary are covered. Limitations per Certificate of Insurance guidelines apply (available upon request).

 Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

- Bone Growth (external)
- Cochlear Implant (Device and Procedure)
- Deep Brain Stimulation
- Gastric Stimulator
- Insertion, Removal, and Revisions of all Implants
- Spinal Cord Stimulator (Device and Procedure)
- Vagus Nerve Stimulator

Infertility Testing Benefit

We cover testing for the diagnosis of infertility. Coverage is subject to Sanford Health Plan Guidelines.

Coverage for testing includes, but is not limited to:

- Transvaginal ultrasound for structural evaluation (limit of 1 per calendar year)
- Sonogram (limit of 1 per calendar year)
- Screenings for stimulations of ovarian reserves and ovarian functions (limit of 1 per screening per calendar year)
- Screenings for assessment of polycystic ovarian syndrome (PCOS) (limit of 1 per calendar year)

- Semen Analysis (limit of 2 per calendar year)

NOT COVERED:

- Any expenses related to surrogate parenting, except if Surrogate is a covered Participant under this SPD and seeking otherwise Covered Services
- Any other services or supplies related to artificial means of conception;
- Cryogenic or other preservation techniques used in such or similar procedures;
- Infertility medication;
- Reversals of prior sterilization procedures; and
- 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;

Lab, x-ray and other diagnostic tests

 **NOTE:** Some of these services fall under High End Imaging and may require Certification. Failure to get Certification may result in a reduction or denial of benefits if the service would not otherwise be covered.

Coverage includes, but is not limited to, the following:

- | | | |
|--------------------------------|--|--------------|
| • Blood tests | • Genetic testing, and counseling, medically necessary to help establish a diagnosis of a new or inheritable disease | • Pathology |
| • CT Scans/MRI | | • PET Scans |
| • DEXA Scans | | • Ultrasound |
| • Electrocardiogram (EKG) | • Non-routine mammograms | • Urinalysis |
| • Electroencephalography (EEG) | • Non-routine Pap tests | • X-rays |
| | • Non-routine PSA tests | |

NOT COVERED:

- Thermograms or thermography

Newborn (Postnatal) Care

A newborn is eligible to be covered from birth. Participants must complete the enrollment process requesting coverage for the newborn within thirty (30) days of the infant's birth. For more information, see Section 1 on Enrollment and *When Dependent Coverage Begins* in this Summary Plan Description.

SHP covers 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 3.2 for coverage information of surgery to correct congenital defects).

SHP will cover other care of an enrolled newborn child who requires non-routine treatment only if we cover the Employee as a Participant. The deductible amount is waived for the first thirty (30) days following the date of birth.

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

NOT COVERED:

- Any expenses related to surrogate pregnancies and/or parenting, except if Surrogate is a covered Participant under this SPD and seeking otherwise Covered Services
- Newborn delivery and nursery charges for adopted Dependents prior to the adoption bonding period

Nutritional Counseling benefit

Nutritional Counseling coverage is limited to 12 visits per calendar year.

NOT COVERED:

- Dietary surveillance and counseling unless part of a wellness visit
- Online assessment and management service provided by a qualified non physician health care professional, internet or electronic communications.

- *Nutritional or food supplements unless for the treatment of PKU*
- *Weight loss or exercise programs or equipment*

Oncology treatment benefits

⚠ NOTE: Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

Oncology treatment coverage is as follows:

- Radiation Therapy. *This is an Oncology Service/Treatment that requires Certification.*
- Chemotherapy, regardless of whether the Participant has separate prescription drug benefit coverage. *This is an Oncology Service/Treatment that requires Certification.*

Orthotic and Prosthetic Devices

⚠ NOTE: Prior Authorization (Certification) may be required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

Orthotic and prosthetic device coverage is as follows:

- Prosthetic limbs, sockets and supplies, and prosthetic eyes
- Limit of twelve (12) Prosthetic Socks per year per limb.
- Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Includes *two (2) external prosthesis per Calendar Year and six (6) bras per Calendar Year*. For double mastectomy: coverage extends to *four (4) external prosthesis per Calendar Year and six (6) bras per Calendar Year*.
- Adjustments and/or modification to the prosthesis required by wear/tear or due to a change in Participant's condition or to improve the function are eligible for coverage and do not require prior authorization.
- Repairs necessary to make the prosthetic functional are covered and do not require authorization. The expense for repairs is not to exceed the estimated expense of purchasing prosthesis.
- Devices permanently implanted that are not Experimental or Investigational Services such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy. *This is a DME that requires Certification.*
- Cranial Prosthesis, including wigs up to \$200.

NOTE: Internal prosthetic devices are paid as Hospital benefits; see Section 3.2 for payment information. Insertion of the device is paid under the surgery benefit.

NOT COVERED:

- *Duplicate or similar items*
- *Experimental and/or Investigational Services not part of an Approved Clinical Trial, unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies*
- *Hair transplants or hair plugs*
- *Replacement or repair of items, if the items are damaged or destroyed by the Participant's misuse, abuse or carelessness; or lost or stolen*
- *Revision/replacement of prosthetics except as noted per Plan guidelines (available upon request)*
- *Service call charges and charges for repair estimates*

Outpatient physical, speech, and occupational therapy services benefit

Outpatient rehabilitative physical, speech, and occupational therapy coverage is as follows:

- Outpatient rehabilitative therapies directed at improving physical functioning of the Participant, which are expected to provide significant improvement within *two (2) months*, as certified on a prospective basis. Coverage includes:
 - Physical Therapy
 - Occupational Therapy
 - Speech Therapy
- Coverage is provided for habilitative services, which includes the management of limitations and disabilities and services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function

- Physical Therapy
- Occupational Therapy
- Speech Therapy
- Includes One-to-one water therapy

NOT COVERED:

- Hot/cold pack therapy including polar ice therapy and water circulating devices
- Maintenance Care that is typically long-term, by definition not therapeutically necessary but is provided at regular intervals to promote health and enhance the quality of life; this includes care provided after maximum therapeutic improvement, without a trial of withdrawal of treatment
- Non-medical special education services or educational counseling for learning disorders or mental disabilities
- Services provided in the Participant's 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
- Speech therapy for the purpose of correcting speech impediments (stuttering or lisps), or assisting the initial development of verbal faculty or clarity; voice training and voice therapy
- Therapy for a primary diagnosis of developmental delay disorder
- Traction services in the home

Phenylketonuria (PKU) treatment services benefit

Phenylketonuria coverage includes 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

Prenatal and Maternity Care

NOTE: Due to the inability to predict admission, you or your Practitioner and/or Provider are encouraged to notify us of your expected due date when the pregnancy is confirmed. You are also encouraged to notify us of the date of scheduled C-sections when it is confirmed. In-Network Participating Practitioner and/or Providers or other health care providers do not need to obtain authorization for prescribing a length of stay of up to 48 hours for a vaginal delivery or of up to 96 hours for a cesarean birth. However, to use certain providers or facilities, or to reduce out-of-pocket costs, precertification may be required.

All pre or post-natal care falling outside the routine care limits below will be covered per applicable cost sharing based on a Participant's Plan. Routine prenatal care (as outlined below) will be covered at 100%:

- Anemia screening; -Limit of One (1) per pregnancy
- Blood type- Limit of One (1) per pregnancy
- Complete blood count (CBC) - Limit of Two (2) per pregnancy
- Depression screening- Limit of One (1) per pregnancy
- Group B streptococci (GBS) - Limit of One (1) per pregnancy
- Hepatitis B screening; -Limit of One (1) per pregnancy
- Hepatitis C Screening - Limit of One (1) per pregnancy
- Human immunodeficiency virus (HIV, during pregnancy) - Limit of One (1) per pregnancy
- Office visits related to a confirmed pregnancy while Participant is pregnant
- Preeclampsia prevention;
- Rh (Rhesus) incompatibility screening: first pregnancy visit and 24-28 weeks gestation;
- Rubella Screening - Limit of One (1) per pregnancy
- Screening for gestational diabetes mellitus during pregnancy – Testing includes a screening blood sugar followed by a glucose tolerance test if the sugar is high; -Limit of One (1) per pregnancy
- Screening for sexually transmitted infections (STIs, during pregnancy) - Limit of One (1) per pregnancy
- Tuberculosis (TB) - Limit of One (1) per pregnancy
- Ultrasound (2D) - Limit of Two (2) per pregnancy
- Urine culture- Limit of One (1) per pregnancy
- Urine dipstick or Urinalysis- Limit of Nine (9) per pregnancy

Breastfeeding support, supplies and counseling are covered in the following manner:

- Sanford Health Plan will allow one breast pump (electric or manual) per pregnancy.
- Breast pump replacement supplies, including tubing, adapters, locking rings, breast shields, splash protectors, and breast pump bottles and caps are covered.
- Breast milk storage bags are covered.
- Bottles which are not specific to breast pump operation and all associated supplies are NOT covered.
- Pumps and supplies are covered only when obtained from a Sanford Health Plan In-Network Participating Practitioner and/or Provider. This does NOT include drugstores or department stores.
- In addition to pumps, consultation with a lactation (breastfeeding) specialist is also covered.

Newborns' Act Disclosure

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 In-Network Participating Practitioners and/or Provider s competent in postpartum care and newborn assessments. In any case, group health plans may not, under federal law, require that a provider obtain Prior Authorization from SHP for prescribing a length of stay not in excess 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.

NOTE: SHP encourages you to participate in our Healthy Pregnancy Program. Visit sanfordhealthplan.com/members/wellness/healthypregnancy to enroll. If you have questions, please contact our care management team Monday through Friday from 8 a.m. to 5 p.m. CST at (888) 315-0884 (TTY: 711).

NOT COVERED:

- *Amniocentesis or chorionic villi sampling (CVS) solely for sex determination*
- *Any expenses related to surrogate pregnancies and/or parenting, except if Surrogate is a covered Participant under this SPD and seeking otherwise Covered Services*
- *Elective abortion services, except when the mother's life is endangered. Prior Authorization/certification required.*
- *Home birth settings, related equipment and fees*
- *Maternity classes and/or education programs*
- *Non-licensed birthing assistance, such as doulas*

Preventive Care – Overview

Preventive Care coverage is as follows:

Under §2713 of the Public Health Service Act (PHS Act) and its implementing regulations relating to coverage of preventive services, the following services, when received from an In-Network Participating Practitioner and/or Provider, are covered without payment of any deductible, copayment, or coinsurance requirement that would otherwise apply:

1. Evidenced-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 (USPSTF) with respect to the individual involved, except for the recommendations of the USPSTF regarding breast cancer screening, mammography, and prevention issued in or around November 2009;
2. Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved;
3. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and
4. With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not included in certain recommendations of USPSTF. You do not need Certification from SHP, or any other person or entity, in order to obtain access to obstetrical and/or gynecological care through an In-Network Participating Practitioner and/or Provider.

NOTE: The above is an overview of preventive services covered by the Plan. **As recommendations change, your coverage may also change.** To view SHP's *Preventive Health Guidelines*, visit www.sanfordhealthplan.com/memberlogin. You may also

request a free copy by calling Customer Service.

NOT COVERED:

- *Non-routine physicals, including but not limited to: 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)*

Preventive Care Benefit – Adults

FOR WOMEN ONLY

The Plan will cover preventive/wellness services in accordance with the age and frequency provisions under the Affordable Care Act as recommendations by the Health Resources and Services Administration (HRSA). Participant payment of deductible, copayment, or coinsurance is not required for the women's preventive care services as recommended by the HRSA. Services include but are not limited to:

- Annual gynecological exam
- Cervical cancer screening; includes Pap smear test at intervals specified in SHP's Preventive Health Guidelines
- Genetic Counseling and evaluation for BRCA Testing and BRCA lab screening for women who have a family history of breast, ovarian, tubal, or peritoneal cancer and an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA₁ or BRCA₂)
- Breast Cancer Mammography screenings every 1 to 2 years for women over 40 years of age
- One Baseline Mammogram for women who are at least 35 but less than 40 years of age
- One breast MRI (with prior authorization) and one mammogram per calendar year for Participants age 30 and older at high risk for breast cancer
- Screening for certain sexually transmitted diseases screening including HIV, gonorrhea, chlamydia and syphilis
- Domestic and interpersonal violence screening and counseling for all women
- Osteoporosis screening for women over age 65 depending on risk factors
- Colonoscopy and sigmoidoscopy starting at age 40+, every 5 years with family history and/or genetic risk for colorectal cancer
- Tobacco Use screening and interventions for all women

FOR MEN ONLY

- One-time screening for abdominal aortic aneurysm by ultrasonography in men aged 65 to 75 who have ever smoked.
- Colonoscopy and sigmoidoscopy starting at age 40+, every 5 years with family history and/or genetic risk for colorectal cancer
- 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

Preventive Care Benefits – Children

The Plan will cover preventive/wellness services in accordance with the age and frequency provisions under the Affordable Care Act as recommendations by the Health Resources and Services Administration (HRSA). Participant payment of any deductible, copayment, or coinsurance is not required for preventive care services as recommended by the HRSA. Services include but are not limited to:

- Pediatric immunizations/vaccines (including those recommended for children by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention)
- Rotavirus vaccine
- Hepatitis B vaccine
- Routine history and physical examination, including:
 - Medical history
 - Height and weight measurement
 - Physical examination
 - Counseling on health improvement, where appropriate, per Preventive Guidelines

- Routine vision (chart) exam – when part of a comprehensive preventive/wellness exam

NOT COVERED:

- *Non-routine physicals, including but not limited to: 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)*

Telehealth Services (Virtual Visits)

Services for telehealth are covered when the following conditions are met:

- The encounter involves a qualifying CPT (Current Procedural Terminology) code that the Health Plan has approved to be conducted by telehealth.
- The services are medically necessary and meet the definition of Covered Health Services as described in this Plan document.
- The technology platform used for the encounter is HIPAA (Health Insurance Portability and Accountability Act) compliant.
- The technology platform used for the encounter allows for fully synchronous, real-time, audio-video connection between the patient and the provider for the duration of the encounter.
- If the patient is physically present with one provider (host location) and is being connected to a remote (distant) provider, charges by the host provider as an originating site to facilitate the connection with the distant provider performing the service are also eligible for coverage, as well as the qualifying charges from the distant provider for conducting the telehealth encounter.

These services shall be available only when services are provided by Participating Providers. Cost share may be subject to applicable Deductible and/or Cost Sharing Amounts and vary based on platform used to complete the visit. For more information, please refer to the Virtual Care Policy at sanfordhealthplan.com.

NOT COVERED:

- *Services not Medically appropriate to do via telehealth.*

Tobacco Cessation Treatment

Tobacco cessation treatment coverage is as follows:

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 when received from an In-Network provider are covered without payment of any Deductible, Copay, or Coinsurance requirement that would otherwise apply. Tobacco cessation treatment includes:

- Screening for tobacco use; and
- At least two (2) tobacco cessation attempts per year (for Participants who use tobacco products). Covering a cessation attempt is defined to include coverage for:
 - Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization, and
 - One ninety (90) day treatment regimen of all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a Health Care Provider without prior authorization.

NOT COVERED:

- *Hypnotism*
- *Acupuncture, unless covered per Medicare Guidelines for treatment of lower back pain*

Transgender Health Services

 **NOTE:** Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

Transgender services related to the treatment of gender dysphoria, including surgical, non-surgical, and gender-specific

preventive services, when deemed medically appropriate and necessary by a qualified health professional. Coverage does not include certain ancillary services, nor does it include cosmetic services such as facial feminization/masculinization surgery.

Determination of medical necessity and prior authorization protocol is based on the most recent, published medical standards set forth by nationally recognized medical experts in the transgender health field. For transgender coverage determination, Sanford Health Plan adheres to the World Professional Association for Transgender Health (WPATH V. 7) Standards of Care, which present evidence based clinical eligibility and readiness criteria for transition-related treatment. Clinical care guidelines are referenced during medical necessity reviews so that coverage is provided consistently and appropriately.

Prior authorization is required. Failure to obtain prior authorization may result in a reduction or denial of benefits.

NOT COVERED:

- *Certain ancillary services*
- *Conversion therapy*
- *Cosmetic services such as facial feminization/masculinization surgery; including but not limited to including but not limited to liposuction, lipofilling, voice modification therapy/surgery, trachea shave/thyroid chondroplasty, gluteal augmentation, hair removal, pectoral implants, or other aesthetic procedures*

Treatment therapy benefits not otherwise listed in this SPD

Treatment therapy is as follows:

- Inhalation Therapy
- Pheresis Therapy
- Respiratory Therapy Services; limited to one (1) program per episode of care
- Pulmonary Rehabilitation Services; limited to one (1) program per episode of care

NOT COVERED:

- *Non-surgical treatments that do not meet the Plan's Medically Necessary guidelines (available upon request)*
- *Treatment received outside of the United States*

3.2 Services Provided by a Hospital or Other Facility

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

- All benefits for authorized services are subject to the definitions, limitations, and exclusions in this Summary Plan Description and are payable only when they are Medically Necessary.
- Benefits will be denied if the Member is not eligible for coverage under this benefit plan on the date services are provided.
- Participating Providers must provide or arrange your care and you must be Hospitalized in a Network Facility.
- Mental Health and Substance Use Disorder benefits provided by a Hospital or other Facility are outlined in Section 3.4.
- Be sure to read Section 2 How You Get Care for valuable information about conditions for coverage.
- **YOUR PRACTITIONER AND/OR PROVIDER MUST GET PRIOR AUTHORIZATION OF SOME OF THESE SERVICES.** Receipt of Prior Authorization (Certification) does not guarantee payment of benefits. See the benefits description below.

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Admissions

⚠ NOTE: Prior Authorization (Certification) is required for all non-emergency Inpatient admissions (a stay overnight) in a hospital or other facility; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

The following Hospital Services are covered:

- Room and board
- Critical care services
- Use of the operating room and related facilities
- General Nursing Services, including special duty Nursing Services if approved by SHP
- 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 and/or Practitioner during Hospitalization. *Some specific services may require authorization. See Section 2 or contact SHP for benefit details.*

Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the Hospital at least forty-eight (48) hours after the procedure. For benefit details, see the Notice of Rights Under the Women's Health and Cancer Rights Act of 1998 (WHCRA) in Section 3.2, under *Reconstructive Surgery*.

NOT COVERED:

- *Admissions to Hospitals only for the convenience of the Participant, the Participant's family or the Participant's Physician or other Practitioner and/or Provider*
- *Custodial or Convalescent care*
- *Intermediate level or domiciliary care*
- *Personal comfort items (telephone, television, guest meals, and guest beds)*
- *Private nursing care*
- *Rest cures*
- *Services to assist in activities of daily living (ADLs)*
- *Take-home drugs*

Skilled nursing care facility benefit

⚠ NOTE: Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

Skilled Nursing Facility Services are covered if approved by SHP in lieu of continued or anticipated Hospitalization. The following Skilled Nursing Facility Services are covered when provided through a licensed nursing Facility or program:

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

Skilled nursing Facility care is limited to thirty (30) days in any consecutive twelve (12) month period. Skilled nursing care in a Hospital shall be covered if the level of care needed by a Participant 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:

- *Convalescent care*
- *Custodial care*
- *Daycare, Attendant, or Homemaker Services*
- *Home delivered meals or laundry services*
- *Intermediate level or domiciliary care*
- *Residential care*
- *Rest cures*
- *Services to assist in activities of daily living*

Hospice care benefit

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

1. The Participant has been diagnosed with a terminal disease and a life expectancy of six (6) months or less;
2. The Participant has chosen a palliative treatment focus (i.e. emphasizing comfort and support services rather than treatment attempting to cure the disease or condition); and
3. The Participant continues to meet the terminally ill prognosis as reviewed by SHP's Chief Medical Officer or designee over the course of hospice care

The following Hospice Services are Covered Services:

1. 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
2. In-home hospice care per Plan guidelines (available upon request)
3. Part-time or intermittent nursing care by a RN, LPN/LVN, or home health aide for patient care up to eight (8) hours per day
4. Social services under the direction of an In-Network Participating Practitioner and/or Provider
5. Psychological and dietary counseling
6. Physical or occupational therapy, as described under *Section 3.1*
7. Consultation and Case Management services by an In-Network Participating Practitioner and/or Provider
8. Medical supplies, DME and drugs prescribed by an In-Network Participating Practitioner and/or Provider
9. Expenses for In-Network Participating Practitioners and/or Provider s for consultant or Case Management services, or for physical or occupational therapists, who are not group members of the hospice, to the extent that coverage for these services is listed in *Section 3.1*, but only where the hospice retains responsibility for the care of the Participant

Not Covered:

- *Independent nursing, homemaker services, or respite care*
- *Fees associated with Room and Board unless Prior Authorization is received pursuant to Medical Necessity guidelines*

Outpatient Surgical Services

 **NOTE:** Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

Outpatient surgical services coverage is as follows;

Health care services furnished in connection with a surgical procedure are covered when performed in an In-Network participating

surgical center, which includes:

- Outpatient Hospital surgical center
- Outpatient hospital services such as diagnostic tests
- Ambulatory surgical center (same day surgery)

NOTE: See SHP's Provider Directory at www.sanfordhealthplan.com for a listing of facilities able to provide services under this benefit. Coverage of some procedures at surgical centers is limited by contract. Check with SHP and your Provider to ensure services from an In- Network participating surgical center will be covered for your particular procedure.

NOT COVERED:

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

Oral and Maxillofacial Surgery benefit

 Indicated services are considered Outpatient Surgery, Services, or DME that require Prior Authorization (Certification); failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

Oral and maxillofacial surgery coverage is as follows:

- Oral surgical procedures limited to services required because of injury, accident, or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.*
 - Care must be received within six (6) months of the occurrence
- Orthognathic Surgery per Plan guidelines. *This is an Outpatient Surgery that requires Certification*
 - 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
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
 - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
 - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
 - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD; Splint limited to one (1) per Participant per benefit period.
- Anesthesia and Hospitalization charges for dental care are covered for a Participant who: *This is an Outpatient Service requires Certification.*
 - is a child age 14 or older (*Certification is not required for children under 14*); or
 - is severely disabled or otherwise suffers from a developmental disability; or
 - has a high-risk medical condition(s) as determined by a licensed Physician that places the Participant at serious risk.
- For more information on dental benefits, see Section 3.6.

NOT COVERED:

- Dental appliances of any sort (except appliances for the treatment of TMJ/TMD, if covered) including but not limited to bridges, braces, appliances for Sleep Apnea (except mandibular advancement devices (MADs)), and retainers
- Dental x-rays
- Extraction of wisdom teeth
- Hospitalization for extraction of teeth
- Natural teeth replacements including crowns, bridges, braces or implants
- Osseointegrated implant surgery (dental implants)
- Routine dental care and treatment
- Services and supplies related to ridge augmentation, implant ology, and Preventive vestibuloplasty
- Shortening of the mandible or maxillae for cosmetic purposes

Reconstructive Surgery

⚠ NOTE: Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

Reconstructive surgery coverage is as follows:

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

Notice of Rights under the Women's Health and Cancer Rights Act Of 1998 (WHCRA):

- In compliance with the Women's Health and Cancer Rights Act of 1998 (WHCRA), coverage for mastectomy related benefits will be provided in a manner determined in consultation with the attending physician and Participant. Deductible and coinsurance apply, as outlined in your Summary of Benefits and Coverage. Mastectomy benefits include:
- Coverage will be provided for reconstructive breast surgery and physical complications at all stages of a mastectomy, including massage therapy and related treatment therapies for lymphedema, for those Participants who had a mastectomy due to 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 Orthotic and Prosthetic devices in Section 3.2 for details).

NOT COVERED:

- *Cosmetic Services and/or supplies to repair or reshape a body structure that is not medically necessary and/or primarily for the improvement of a Participant'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 body contouring procedures, and body lift procedures. Does not apply to medically necessary services provided pursuant to WHCRA.*
- *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, unless covered under Plan guidelines for mastectomy benefits.*

Morbid Obesity Surgery

NOTE: This is an Outpatient Surgery and Certification is required. Failure to get Prior Authorization will result in a reduction or denial of benefits. (See *Services requiring Prior Authorization in Section 2.*)

Morbid obesity surgery coverage is as follows:

- Surgical treatment of morbid obesity (bariatric surgery) is covered per Plan guidelines. Medical management policies define the criteria and coverage limitations.
- Benefits for surgical services performed for the treatment of morbid obesity are available only when:
 - Prior Authorization is obtained; and
 - Subject to Plan guidelines (available upon request); and
- Limited to a lifetime Maximum of one (1) operative procedure per Participant.

NOT COVERED:

- *Abdominoplasty*
- *Appetite suppressants and supplies of a similar nature*
- *Liposuction, gastric balloons, or wiring of the jaw (unless otherwise related to a covered injury or illness)*
- *Nutritional or food supplements (services supplies and/or nutritional sustenance products or food related to enteral feeding, except when it's the sole means of nutrition)*
- *Panniculectomy that does not meet Plan guidelines*
- *Weight loss or exercise programs that do not meet the Plan's medical necessity coverage guidelines*

Transplant Services

 **NOTE:** Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

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

- Bone marrow or stem cell acquisition and short-term storage during therapy for a Participant with a covered illness
- Drugs (including immunosuppressive drugs)
- 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
- Post-transplant care and treatment
- Psychological testing
- Pre-operative care
- 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
- Second Opinions
 - SHP will notify the Member if a second opinion is required at any time during the determination of benefits period. If a Member is denied a transplant procedure by the transplant facility, the Plan will allow them to go to a second transplant facility for evaluation. If the second facility determines, for any reason, that the Member is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third transplant facility accepts the Member for the procedure.
- Short-term storage of umbilical cord blood for a Participant with a malignancy undergoing treatment when there is a donor match.
- Supplies (must be Prior Authorized)
- Transplant procedure, facility and professional fees

NOT COVERED:

- *Artificial organs, any transplant or transplant services not listed above*
- *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*
- *Expenses incurred by a Participant as a donor, unless the recipient is also a Participant Costs related to locating 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 SHP's Chief Medical Officer or designee*
- *Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating Provider or Non-Center Of Excellence*
- *Storage of stem cells, including storing umbilical cord blood of non-diseased persons for possible future use*
- *Transplant evaluations with no end organ complications*
- *Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria*

Anesthesia

The Plan covers services of an anesthesiologist or other certified anesthesia Provider in connection with an authorized inpatient or outpatient procedure or treatment.

Clinical Trials

 **NOTE:** Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

We cover Routine Patient Costs when provided as part of an Approved Clinical Trial if the services are otherwise Covered Services. An In-Network Participating Practitioner and/or Provider must provide Sanford Health Plan notice of a Participant's participation in an Approved Clinical Trial.

Routine Patient Costs means the cost of Medically Necessary Health Care Services related to the care method that is under evaluation in an Approved Clinical Trial. Routine Patient Costs do not include any of the following.

- The Health Care Service that is the subject of the Approved Clinical Trial.
- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service that is the subject of the Approved Clinical Trial.
- Any Health Care Service provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.
- An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
- Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a facility where an Approved Clinical Trial is conducted.
- A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.
- A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.

NOT COVERED:

- *Extra care costs related to taking part in a clinical trial such as additional tests that a Participant may need as part of the trial, but not as part of the Participant's routine care.*
- *Research costs related to conducting the Approved Clinical Trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes*

3.3 Emergency Services/Accidents

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

- All benefits for authorized services are subject to the definitions, limitations, and exclusions in this Summary Plan Description and are payable only when SHP determines they are Medically Necessary.
- Be sure to read Section 2 How You Get Care for valuable information about conditions for coverage.

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What is an Emergency Medical Condition?

An Emergency Medical Condition is the sudden and unexpected onset of a health condition that, based on a Prudent Layperson's judgment, 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, or with respect to a pregnant woman, the health of the woman or her unborn child, 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, Participants should contact their Primary Care Practitioner and/or Provider (PCP) immediately, if one has been selected, and follow his or her instructions. A Participant may always go directly to an In-Network participating urgent care or after-hours clinic. A Provider Directory is available on request or at www.sanfordhealthplan.com.

We cover worldwide emergency services necessary to screen and stabilize Participants without Certification in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. To be eligible for benefits after the screening and stabilization of an Emergency Medical Condition or Urgent Care Situation, follow-up care or scheduled care must be received from an In-Network Participating Practitioner and/or Provider.

Emergency inside SHP Service Area

If an Emergency Medical Condition arises, Participants should proceed to the nearest emergency Facility that is an In-Network Participating Practitioner and/or Provider. If the Emergency Medical Condition is such that a Participant cannot go safely to the nearest In-Network participating emergency Facility, then the Participant should seek care at the nearest emergency Facility.

The Participant, or a designated relative or friend, must notify SHP and the Participant's Primary Care Practitioner and/or Provider, if one has been selected, as soon as reasonably possible after receiving treatment for an Emergency Medical Condition; but no later than forty-eight (48) hours after the Participant is physically or mentally able to do so.

The Health Plan covers emergency services necessary to screen and stabilize Participants without pre-certification in cases where a Prudent Layperson reasonably believed that an emergency medical condition existed. With respect to care obtained from a Non-Participating Practitioner and/or Provider or an Out-of-Network Participating Practitioner and/or Provider within SHP's Service Area, the Plan shall cover emergency services necessary to screen and stabilize a Participant and may not require Prospective (pre-service) Review of such services if a Prudent Layperson would have reasonably believed that use of a Participating and/or In-Network Practitioner and/or Provider would result in a delay that would worsen the emergency, or if a provision of federal 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 an In-Network Participating Practitioner and/or Provider.

If a Participant is admitted to a Non-Participating and/or Out-of-Network Facility, then SHP 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 Participant may be transferred to an In-Network Participating Facility.

Emergency outside SHP Service Area

If an Emergency Medical Condition occurs when traveling outside of SHP's Service Area, Participants should go to the nearest emergency Facility to receive care. The Participant, or a designated relative or friend, must notify SHP and the Participant's Primary Care Practitioner and/or Provider, if one has been selected, as soon as reasonably possible after receiving treatment for an Emergency Medical Condition, but, no later than forty-eight (48) hours after the Participant is 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 Participant has traveled outside the Service Area for the purpose of receiving such treatment.

If an Urgent Care Situation occurs when traveling outside of the Service Area, Participants should contact their Primary Care Practitioner and/or Provider immediately, if one has been selected, and follow his or her instructions. If a Primary Care Practitioner and/or Provider has not been selected, the Participant should contact SHP and follow SHP's instructions. Coverage will be provided for urgent care situations outside the Service Area at the In-Network level unless the Participant has traveled outside the Service Area for the purpose of receiving such treatment.

NOTE: There is no coverage for non-Emergency or non-Urgent Medical Care when traveling outside SHP's Service Area, unless such care is provided by an In-Network Participating Provider. Participant will be responsible to pay 100% of the charges for non-Emergency services received from Non-Participating Providers or Out-of-Network Participating Practitioner and/or Providers.

NOTE: There is no coverage for care received from a Non-Participating Provider or Out-of-Network Provider outside of the Service Area, except in the case of an Emergency Medical Condition or Urgent Care Situation.

NOT COVERED:

- *Emergency care provided outside the Service Area if the need for care could have been foreseen before leaving the Service Area*

Coverage outside of the United States

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

The Health Plan covers worldwide emergency services necessary to screen and stabilize Participants without Prior Authorization in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. Network restrictions do not apply to emergency services received from Practitioners and/or Providers outside of the United States.

Covered services for medically necessary Emergency and Urgent care services received in a foreign country are covered at the In-Network level. There is no coverage for elective (non-emergent or urgent) health care services outside the United States, including when a Participant travels to another country for the purpose of seeking medical treatment outside the United States.

Ambulance and Emergency Transportation Services

 **NOTE:** Prior Authorization (Certification) is required for all Air Ambulance and Non-Emergent Transportation; failure to get Certification may result in a reduction or denial of benefits.

Ambulance and emergency transportation services coverage is as follows:

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

1. Medically Necessary; and
2. To the nearest In-Network Participating Practitioner and/or Provider equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by SHP.

NOT COVERED:

- *Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other health care services*

- *Services and/or travel expenses related to a Non-Emergency Medical Condition*
- *Transfers performed only for the convenience of the Participant, the Participant's family or the Participant's Physician or other Practitioner and/or Provider*

3.4 Mental Health and Substance Use Disorder Benefits

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

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- All benefits for authorized services are subject to the definitions, limitations, and exclusions in this Summary Plan Description and are payable only when they are Medically Necessary.
- Benefits will be denied if the Member is not eligible for coverage under this benefit plan on the date services are provided.
- Be sure to read Section 2 How You Get Care for valuable information about conditions for coverage.
- **YOUR PRACTITIONER AND/OR PROVIDER MUST GET PRIOR AUTHORIZATION OF SOME OF THESE SERVICES.** Receipt of Prior Authorization (Certification) does not guarantee payment of benefits. See the benefits description below.

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Mental Health Treatment Services

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limitations that apply to the Plan's mental health and/or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. In addition, mental health and substance use disorder benefits are not subject to separate cost sharing requirements or treatment limitations. Mental health and substance use disorders are covered consistent with generally recognized independent standards of current medical practice, which includes the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Diseases (ICD).

Coverage is provided for mental health conditions which current prevailing medical consensus affirms substantially impairs perception, cognitive function, judgment, and/or emotional stability, and limits the life activities of the person with the condition(s). This includes but is not limited to the following conditions: schizophrenia; schizoaffective disorders; bipolar disorder; major depressive disorders (single episode and/or recurrent); obsessive-compulsive disorders; attention-deficit/hyperactivity disorder; autism spectrum disorder(s); eating disorders; post-traumatic stress disorders (acute, chronic, or with delayed onset); and anxiety disorders that cause significant impairment of function.

Mental health benefits are covered with the same Copays, Deductibles, Coinsurance factors, and restrictions as other medical/surgical benefits under the Plan. Coverage for mental health conditions includes:

- Diagnostic tests
- Electroconvulsive therapy (ECT)
- Group Therapy
- Inpatient services, including Hospitalizations
- Intensive Outpatient Programs
- Medication management
- Outpatient Professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, or other qualified mental health professionals
- Partial Hospitalization

⚠ NOTE: The following admissions or outpatient services require Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

- All Inpatient services, including services provided by a Hospital or Residential Treatment Facility

NOT COVERED:

- Convalescent care
- Domiciliary care, maintenance care, or Long-Term Residential Care
- Educational or non-medical services for learning disabilities or behavioral problems
- Educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)
- Marriage counseling; pastoral counseling; financial or legal counseling; and custodial care counseling

- Milieu therapy
- Sensitivity training
- Services related to environmental change

Applied Behavior Analysis for Treatment of Autism Spectrum Disorder

Applied Behavior Analysis (ABA) is a covered service for the treatment of Participants diagnosed with Autism Spectrum Disorder.

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

Participant must be diagnosed with Autism Spectrum Disorder by a Practitioner and/or Provider qualified to diagnose the condition.

1. ABA as behavioral health treatment is expected to result in the achievement of specific improvements in the Participant's functional capacity of their autism spectrum disorder, subject to Plan medical policy and medical necessity guidelines
2. ABA services are only covered when provided by a licensed or certified practitioner as defined by law.
3. Coverage of ABA is subject to preauthorization, concurrent review, and other care management requirements.
4. Limits are subject to the Plan's medical management policies and determinations of Medical Necessity

NOT COVERED:

- Tests considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: allergy testing, celiac antibody testing, hair analysis, testing for mitochondrial disorders, and micronutrient testing.
- Therapies considered experimental or investigational for the treatment of autism spectrum disorder, including but not limited to: auditory integration therapy, biofeedback, chelation therapy, hippotherapy, equestrian therapy, and hyperbaric oxygen therapy

Substance Use Disorder Treatment Services

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the financial requirements and treatment limitations that apply to the Plan's mental health and/or substance use disorder benefits are no more restrictive than the predominant financial requirements or treatment limitations that apply to substantially all medical/surgical benefits. In addition, mental health and substance use disorder benefits are not subject to separate cost sharing requirements or treatment limitations. Mental health and substance use disorders are covered consistent with generally recognized independent standards of current medical practice, which includes the current editions of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD).

Substance use disorder benefits are covered with the same Copays, Deductibles, Coinsurance factors, and restrictions as other medical/surgical benefits under the Plan. Coverage for substance use disorders includes:

- Addiction treatment, including for alcohol, drug-dependence, and gambling issues
- Inpatient services, including Hospitalization
- Intensive Outpatient Programs
- Outpatient professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, Licensed Chemical Dependency Counselors, or other qualified mental health and substance abuse disorder professionals
- Partial Hospitalization

⚠ NOTE: The following admissions or outpatient services require Prior Authorization (Certification) is required; failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

- All Inpatient services, including services provided by a Hospital or Residential Treatment Facility

NOT COVERED:

- Confinement Services to hold or confine a Participant under chemical influence when no Medically Necessary services are provided, regardless of where the services are received (e.g. detoxification centers)
- Convalescent care
- Domiciliary care or Long-Term Residential Care
- Educational or non-medical services for learning disabilities

- *Marriage counseling; pastoral counseling; financial or legal counseling; and custodial care counseling*
- *Milieu therapy*
- *Sensitivity training*
- *Services related to environmental change*

3.5 Outpatient Prescription Medication or Drug Benefits

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

- SHP covers prescribed drugs and medications, as described in this Section
- All benefits are subject to the definitions, limitations and exclusions in this Summary Plan Description and are payable only when they are Medically Necessary.
- Be sure to read Section 2 How You Get Care, for valuable information about conditions for coverage.
- **YOU MUST GET PRIOR AUTHORIZATION (Certification) OF SOME OF THESE SERVICES.** See the benefit description below.
- Refer to the Introduction section at the beginning of this document for instructions on contacting Pharmacy Management.

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Pharmacy Benefit Description

- You must fill prescriptions at an In-Network Plan Participating pharmacy. If you choose to go to a Non-Participating or Out-of-Network pharmacy, you will be responsible for all (100%) of the cost of the prescription to the pharmacy. Specialty drugs must be obtained through SHP's contracted specialty pharmacy. North Dakota Participants may utilize any pharmacy to fill specialty medications.
- To fill a prescription, you must present your member ID card to your pharmacy; if you do not you will be responsible for all (100%) of the cost(s) of the prescription to the pharmacy.
- Sanford Health Plan uses a formulary; a list of prescription drug products, which are covered by SHP for dispensing to Participants when appropriate. The formulary will be reviewed regularly, and medications may be added or removed from the formulary throughout the year. SHP will notify you of the changes as they occur. For a copy of the formulary, contact Pharmacy Management or log in to your Member Portal at www.sanfordhealthplan.com/memberlogin.
- SHP reserves the right to maintain a drug listing of medications that are not available/excluded for coverage per SHP medical necessity and limitation guidelines. Payment for excluded medications will be the Participant's responsibility in full. Participants may request an appeal (review of an Adverse Determination) based on medical necessity for Non-Covered medications. For details, refer to the appeals section of this policy.
- SHP will utilize pharmacists practitioners and/or providers to review formulary exception requests and promptly grant an exception to the drug formulary for a Participant when the prescriber indicates that:
 - The formulary drug(s) causes an adverse reaction in the patient;
 - The formulary drug(s) is/are contraindicated for the patient; or
 - The prescription drug must be dispensed as written to provide maximum medical benefit to the patient.
- To request a formulary exception, please call Pharmacy Management or send a request by logging into the provider portal at www.sanfordhealthplan.com/memberlogin. Participants must first try formulary medications before an exception to the formulary will be made unless the prescriber and SHP determine that use of the formulary drug may cause an adverse reaction or be contraindicated for the Participant. If an exception is granted, coverage of the non-formulary drug will be provided for the duration of the prescription, including refills. See Pharmaceutical Review Requests and Exception to the Formulary Process in Section 2 for details.
- With certain medications, SHP requires a trial of first-line medications, typically generics, before more expensive name brand medications are covered. If the desired clinical effect is not achieved or a side effect is experienced, then a second line medication may be tried. If a step therapy rule is not met at the pharmacy, coverage will be determined by Certification (pre-approval) Review. Request Certification by contacting Pharmacy Management. Refer to the Formulary for a complete list of medications that require step therapy.
- To be covered by SHP, certain medications require Certification (pre-approval) to ensure medical necessity. This can be in the form of written or verbal certification by a prescriber. To request certification, contact Pharmacy Management. Refer to the formulary for a complete list of medications that require Certification.
- Certain medications have a quantity limit to ensure the medication is being used as prescribed and the participant is receiving the most appropriate treatment based on manufacturer's safety and dosing guidelines. Refer to your

formulary for a complete list of medications with quantity limits.

- 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 SHP)
- Specialty medications can be filled up to a thirty (30) day supply per copay (or less, if prescribed) at one time (unless otherwise approved by SHP).
- If you traveling 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. Vacation supplies are limited to the time period that the Participant is enrolled in SHP and one vacation override per medication per calendar year. Contact Pharmacy Management to request a vacation override.
- If you receive a brand name drug when there is a generic equivalent or biosimilar alternative available, you will be required to pay a brand penalty. The brand penalty consists of the price difference between a brand name drug and the generic or biosimilar alternative, in addition to applicable cost sharing (copay and/or deductible/coinsurance) amounts. Brand penalties do not apply to your deductible or maximum out of pocket.
- Prescription refills will be covered when 75% of your prescription has been used up with a surplus limit of 10 days. The surplus limit is calculated based on the amount of medication obtained over the previous 180 days and limits you to a maximum of 10 days of additional medication at any given time.
- For participants enrolled in a High Deductible Health Plan, the prescription drug benefit is subject to your deductible and coinsurance amounts.

Covered medications and supplies

To be covered by SHP, prescriptions must be:

1. Prescribed or approved by a licensed physician, physician assistant, nurse practitioner or dentist;
2. Listed in the Plan Formulary, unless certification (authorization) is given by SHP;
3. Provided by an In-Network Participating Pharmacy except in the event of urgent or emergent medical situations (if a prescription is filled at a Non-Participating and/or Out-of-Network Pharmacy in non-urgent or emergent medication situations, the Participant will be responsible for the cost of the prescription medication in full.);
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

Covered Types of Prescriptions

1. Federal Legend Drugs. Any medicinal substance which bears the legend: “Caution: Federal Law prohibits dispensing without a prescription,” except for those medicinal substances classified as exempt narcotics pursuant to applicable laws and regulations.
2. Self-administered medications—medications such as subcutaneous injections, oral or topical medications, or nebulized inhalation are to be obtained from a network pharmacy.
3. Medicinal substances (legally restricted medications) that may only be dispensed by a prescription, according to applicable laws and regulations.
4. Compounded medications are only covered when the medication has at least one ingredient that is a federal legend or state restricted drug in a therapeutic amount.
5. Diabetic supplies, such as insulin, a blood glucose meter, blood glucose test strips, diabetic needles and syringes are covered when medically necessary. (See section 3.1 for Diabetic supplies, equipment, and self-management training benefits.)
 - a. A thirty (30) day supply of diabetic needles and syringes; and
 - b. Diabetic testing strips are limited to two-hundred-five (205) per month, with a written doctor’s order.
 - c. Blood glucose meters are limited to one (1) meter per calendar year
6. Generic oral contraceptives, injections and/or devices will be covered by SHP at 100% (no charge).

NOT COVERED:

- Any medication equivalent to an OTC medication except for drugs that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force and only when prescribed by a health care Practitioner and/or Provider
- Compound medications containing any combination of the following: Baclofen, Bromfenac, Bupivacaine, Cyclobenzaprine,

Gabapentin, Ketamine, Ketoprofen or Orphenadrine

- *Compound medications with no legend (prescription) medications*
- *Drug Efficacy Study Implementation (“DESI”) drugs*
- *Experimental or Investigational medications or medication usage pursuant to the Plan’s medical coverage policies*
- *Food supplements and baby formula (except to treat phenylketonuria (PKU) or otherwise required to sustain life), nutritional and electrolyte substances*
- *Lifestyle medications (i.e. medications used to treat sexual dysfunction)*
- *Medication used to treat infertility*
- *Medications and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless the Practitioner certifies off-label use with a letter of medical necessity)*
- *Medications for cosmetic purposes, including baldness, removal of facial hair, and pigmenting or anti-pigmenting of the skin*
- *Medications not listed in the Plan’s Formulary*
- *Medications obtained at a Non-Participating and/or Out-of-Network Pharmacy;*
- *Medications that are obtained without Prior Authorization or a Formulary exception approved from the Plan*
- *Medications that may be received without charge under a government program, unless coverage is required for the medication*
- *Medications that provide little or no evidence of therapeutic advantage over other products available*
- *Medications that require professional administration (may include: intravenous (IV) infusion or injection, intramuscular (IM) injections, intravitreal (ocular) injection, intra-articular (joint) injection, intrathecal (spinal) injections) will apply to the Participant’s medical benefit;*
- *Non-FDA approved Medical Cannabis and its equivalent*
- *Orthomolecular therapy, including nutrients or vitamins unless otherwise specified as covered in this document*
- *Over-the-counter (OTC) medications vitamins and/or supplements, equipment or supplies (except for insulin and select diabetic supplies, e.g., insulin syringes, needles, test strips and lancets) that by Federal or State law do not require a prescription order*
- *Refills of any prescription older than one year*
- *Repackaged medications*
- *Replacement of a prescription medication due to loss, damage, or theft*
- *Self-administered medications dispensed in a Provider’s office or non-retail pharmacy location*
- *Unit dose packaging*
- *Whole Blood and Blood Components Not Classified as Medications in the United States Pharmacopoeia*

3.6 Dental Benefits

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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 Summary Plan Description and are payable only when they are Medically Necessary.
- The Plan covers 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 3.2 for inpatient Hospital benefits. The Plan does not cover the dental procedure unless it is described below.
- Be sure to read Section 2 How You Get Care for valuable information about conditions for coverage.

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Dental Benefit Description

 **NOTE:** Indicated services are considered Outpatient Surgery, Services, or DME that require Prior Authorization (Certification); failure to get Certification may result in a reduction or denial of benefits. Refer to www.sanfordhealthplan.com/members/prior-authorization.

Dental benefit coverage is as follows:

- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
 - Services for the Treatment and Diagnosis of TMJ/TMD subject to Medical Necessity defined by Sanford Health Plan's Medical coverage guidelines
 - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers and is Medically Necessary pursuant to Sanford Health Plan's medical coverage guidelines.
 - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD;
 - Splint limited to one (1) per Participant per benefit period.
- Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth, as long as the Participant was covered under this Contract during the time of the injury or illness causing the damage. *This is an Outpatient Surgery that requires Certification.*
 - Associated radiology services are included
 - Care must be received within six (6) months of the occurrence
 - Coverage applies regardless of whether the services are provided in a Hospital or a dental office
 - Extractions when medically necessary because of injury, accident, or cancer when Sanford Health Plan internal guidelines are met
 - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
- Anesthesia and Hospitalization charges for dental care are covered for a Participant who: *This is an Outpatient Service that requires Certification.*
 - is a child age 14 or older (*Certification is not required for children under 14*); or
 - is severely disabled or otherwise suffers from a developmental disability as determined by a licensed Physician; or
 - has a high-risk medical condition(s) as determined by a licensed Physician that places the Participant at serious risk.

NOT COVERED:

- Dental appliances of any sort (except appliances for treatment of TMJ/TMD, if covered), including but not limited to bridges, braces, appliances for Sleep Apnea, and retainers
- Dental x-rays
- Extraction of wisdom teeth
- Hospitalization for extraction of teeth
- Natural teeth replacements including crowns, bridges, braces or implants
- Osseointegrated implant surgery (dental implants)
- Removal of wisdom teeth
- Routine or preventive dental care and treatment

- *Services and supplies related to ridge augmentation, implantology, and Preventive vestibuloplasty.*
- *Shortening of the mandible or maxillae for cosmetic purposes*

3.7 Out-of-Network Benefit Limitations

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This Medical Benefit Plan does not cover any Out-of-Network services unless:

- There is an emergency or urgent care situation; or
- Prior Authorization is granted (See Services requiring Certification in Section 2)

The Participant is responsible for all charges associated with Out-Of-Network Services unless the above conditions are met.

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Benefit Description

“Out-of-Network” means services that do not fit the definition of “In-Network” Coverage as set forth in Section 2. Services considered Out-of-Network are those:

1. from Non-Participating Practitioners and/or Providers when Sanford Health Plan has not authorized the referral or the service;
2. from a Participating Practitioner and/or Provider that is not “In-Network” when Sanford Health Plan has not authorized the referral or the service;
3. from a Participating Practitioner and/or Provider outside of the Sanford Health Plan Service Area when the Participant is traveling outside of the covered service area for the purpose of receiving such services and:
 - a. an In-Network Participating Practitioner and/or Provider has not recommended the referral; and
 - b. Sanford Health Plan has not authorized the referral or the service to a Participating Practitioner and/or Provider outside of Sanford Health Plan’s Service Area.

NOTE: When you obtain non-emergency or non-urgent medical treatment from a Non-Participating Practitioner and/or Provider or from an Out-of-Network Participating Provider, without authorization from us, you are responsible for all Out-of-Network charges.

Section 4. Limited and Non-Covered Services

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

4.1 General Exclusions

1. Alternative treatment therapies including, but not limited to: acupuncture, unless covered per Medicare Guidelines for treatment of lower back pain, acupressure, massage therapy unless covered per plan guidelines under WHCRA for mastectomy/lymphedema treatment, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, sleep therapy (except for treatment of obstructive apnea), or therapeutic touch
2. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this SPD
3. Any fraudulently billed charges or services received under fraudulent circumstances
4. Any services or supplies for the treatment of obesity that do not meet Sanford Health Plan's coverage guidelines, including but not limited to: dietary regimen (except as related to covered nutritional counseling); nutritional supplements or food supplements; and weight loss or exercise programs
5. Autopsies, unless the autopsy is at the request of The Plan in order to settle a dispute concerning provision or payment of benefits. The autopsy will be at the Plan's expense.
6. Charges for duplicating and obtaining medical records from Non-Participating Providers unless requested by us
7. Charges for professional sign language and foreign language interpreter services unless required by state or federal law
8. Charges for sales tax, mailing, interest and delivery
9. Charges for services determined to be duplicate services
10. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner and/or Provider or electronic consultations, unless otherwise stated in this SPD
11. Charges that exceed the Maximum Allowed Amount for Non-Participating Providers
12. Complications resulting from non-covered or denied Health Care Services.
13. Cosmetic Services and/or supplies to repair or reshape a body structure not Medically Necessary and/or primarily for the improvement of a Participant'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
14. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management
15. Experimental and Investigational Services not part of an Approved Clinical Trial unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies
16. Food items for medical nutrition therapy (except as specifically allowed in the Covered Benefits Section of this Policy)
17. Health Care Services covered by any governmental agency/unit for military service-related injuries/diseases, unless applicable law requires primary coverage for the same
18. Health Care Services for injury or disease due to voluntary participation in a riot, unless source of injury is a result of domestic violence or a medical condition
19. Health Care Services for sickness or injury sustained in the commission of a felony, unless source of injury is a result of domestic violence or a medical condition
20. Health Care Services performed by any Provider who is a Participant of the Participant's immediate family, including any person normally residing in the Participant's home. This exclusion does not apply in those areas in which the immediate family participant is the only Provider in the area. If the immediate family member is the only In-Network Participating Practitioner and/or Provider in the area, the Participant may be treated by that Provider provided they are acting within the scope of their practice. The Participant may also go to a Non-Participating Provider and receive In-Network coverage (Section 4). If the immediate family member is not the only In-Network Participating Practitioner and/or Provider in the area, the Participant must go to another In-Network Participating Practitioner and/or Provider in order to receive coverage at the In-Network level.
21. Health Care Services prohibited state or federal rule, law, or regulation
22. Health Care Services provided either before the effective date of the Participant's coverage or after the

Participant's coverage is terminated.

23. Health Care Services received from a Non-Participating Provider, unless otherwise specified in this Contract.
24. Health Care Services required while incarcerated in a federal, state or local penal institution or required while in custody of federal, state or local law enforcement authorities, including work release programs, unless otherwise required by law or regulation
25. Health Care Services that are the responsibility of a Third-Party Payor
26. Health Care Services that we determine are not Medically Necessary
27. Health services received outside of the United States that are not Medically Necessary emergency or urgent care services
28. 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. Charges related to Iatrogenic illness or injury are not the responsibility of the Participant.
29. Inpatient services provided at a Residential Treatment Facility if treatment is not provided at an acute level of care with 24-hour registered nursing care under the supervision of a Chief Medical Officer.
30. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics
31. Liposuction, gastric balloons, or wiring of the jaw (unless otherwise related to a covered injury or illness)
32. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events. Participating Providers are not permitted to bill Participants for services related to such events.
33. Removal of skin tags
34. Sequela, which are primarily cosmetic that occur secondary to a weight loss procedure (e.g., Panniculectomy, breast reduction or reconstruction)
35. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home that are not Medically Necessary
36. Services for which the Participant has no legal obligation to pay or for which no charge would be made if the Participant did not have health plan or insurance coverage.
37. 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
38. Services that are not Health Care Services
39. Services to assist in activities of daily living
40. Special education, including lessons in sign language to instruct a Participant, whose ability to speak has been lost or impaired, to function without that ability, is not covered
41. Subsequent surgeries when no tangible evidence of Medical Necessity or improved quality of life exists.
42. Therapy and service animals, including those used for emotional or anxiety support
43. Voluntary or involuntary drug testing unless a part of a Plan approved treatment plan
44. Treatment received outside the Service Area, other than during an Emergency Medical Condition or Urgent Care Situation, if a Member travels out of the Service Area for the purpose of seeking medical treatment, unless care is received from an In-Network Participating Practitioner and/or Provider.

4.2 Services Covered By Other Payors

The following are excluded from coverage:

1. Health services for which other coverage is either (1) required by federal law to be purchased or provided through other arrangements or (2) has been made available to and was purchased by the Covered Person. Examples include coverage required by Workers' compensation, no-fault auto insurance, medical payments coverage or similar legislation.

The Plan is not issued in lieu of nor does it affect any requirements for coverage by Workers' 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 paid 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 the Participant 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, Participant agrees to reimburse the Plan the full amount which the Plan has paid for Health Care Services when entering into a settlement

or compromise agreement relating to compensation for the Health Care Services covered by, or at any Workers' Compensation, or as part of any Workers' Compensation Award.

The Plan reserves its right to recover against Participant even though:

- a. The Workers' 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 Participant or the Workers' Compensation carrier; or
 - d. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise. Participant 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.
2. Health Care Services received directly from Providers employed by or directly under contract with the Participant'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 for or provided by the Plan, the Plan may exercise its Rights of Subrogation.
 4. Health Care Services covered by any governmental health benefit program such as Medicare, Medicaid, and ESRD, unless applicable law requires the Plan to provide coverage for the same. See Section 6, Coordination of Benefits, for details.

4.3 Services and Payments that are the Responsibility of Participant

1. Out-of-pocket costs, including Copays, Deductibles, and Coinsurance are the responsibility of the Participant in accordance with the Summary of Benefits and Coverage, and your Formulary. Additionally, the Participant 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 Participant neither is legally nor as customary practice required to pay in the absence of a group health plan or other coverage arrangement.
4. Services received at the Out-of-Network benefit level. **There is no coverage for health care services received from a Non-Participating and/or Out-of-Network Practitioner and/or Provider other than for an Emergency or Urgent Care Medical Condition.**

Section 5. How Services are Paid by the Plan

5.1 Reimbursement of Charges by Participating Providers

You will not have to file claims when:

1. you receive services at In-Network, Participating Providers and facilities; or
2. obtain your prescription drugs at In-Network pharmacies. You must present your current identification card and pay your Copay.

When a Participant receives Covered Services from an In-Network Participating Practitioner and/or Provider, SHP will pay the In-Network Participating Practitioner and/or Provider directly, and the Participant will not have to submit claims for payment. The Participant's only payment responsibility, in this case, is to pay the In-Network Participating Practitioner and/or Provider, at the time of service, any Copay, Deductible, or Coinsurance amount that is required for that service. In-Network Participating Providers agree to accept either Sanford Health Plan's payment arrangements or the negotiated contract amounts.

Time Limits. In-Network Participating Practitioner and/or Provider must file claims to SHP within one hundred eighty (180) days after the date that the cost was incurred. If the Participant fails to show his/her Sanford Health Plan ID card at the time of service, then the Participant may be responsible for payment of claim after In-Network Participating Practitioner and/or Provider timely filing period of one hundred eighty (180) days has expired.

In any event, the claim must be submitted to Sanford Health Plan no later than one hundred eighty (180) days after the date that the cost was incurred, unless the claimant was legally incapacitated.

5.2 Balance Billing from Non-Participating Providers

Balance billing, sometimes referred to as surprised billing, is the practice of a medical provider charging a patient for the difference between the total cost of services being billed and the amount the insurance pays. When a Member receives Covered Services from an In-Network Participating Practitioner and/or Provider, the Member is protected from balance billing because the provider cannot attempt to collect charges above what Sanford Health Plan reimburses. When Sanford Health Plan does not have a contractual relationship in place and the provider is a Non-Participating Provider, they may not accept Sanford Health Plan's payment arrangements and members may be balanced billed for services received.

Participants may be balance billed in emergency situations even when Sanford Health Plan covers all of the charges at an In-Network Level if the provider is a Non-Participating Provider who will not accept our payment as full and final. In such circumstances, the Non-Participating Provider must satisfy the Notice and Consent Process and Requirements before sending surprise bills. Out-of-Network facilities and providers are prohibited from sending surprise bills for out-of-network cost sharing without signed consent from the Member. Please check the Sanford Health Plan provider directory before receiving services to make sure you are seeing an In-Network Participating Practitioner and/or Provider.

If you think you've been wrongly billed, contact the No Surprises Help Desk (NSHD) at 1-800-985-3059 or visit <https://www.cms.gov/nosurprises/consumers> for more information about your rights under federal law. For Minnesota residents, you may also contact the Minnesota Department of Commerce at (651) 539-1600 or 1-800-657-3602 for more information about your rights under Minnesota law.

5.3 Claims Submission

You may need to file a claim when you receive emergency or urgent care services from Non-Participating Practitioner and/or Providers. Sometimes these Practitioner and/or Providers submit a claim to SHP directly. Check with the Practitioner and/or Provider to make sure they are submitting the claim. You are responsible for making sure claim is submitted to SHP within one hundred eighty (180) days after the date that the cost was incurred. **If you, or the Non-Participating Practitioner and/or Provider, do not file the claim within one hundred eighty (180) days after the date that the cost was incurred you will be responsible for payment of the claim.**

If you need to file the claim, here is the process:

The Participant must give SHP written notice of the costs to be reimbursed. Claim forms are available from Customer Service to aid in this process. Bills and receipts should be itemized and show:

- Participant's name and ID number;
- Name and address of the Physician or Facility that provided the service or supply;
- Dates Participant received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- 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.

Health care Services Received Outside of the United States. Covered services for medically necessary emergency services received in a foreign country are covered at the In-Network level. There is no coverage for elective health care services if a Participant travels to another country for the purpose of seeking medical treatment outside the United States.

Time Limits. Claims must be submitted to SHP within one hundred eighty (180) days after the date that the cost was incurred. If you, or the Non-Participating Practitioner and/or Provider, file the claim after the one hundred eighty (180) timely filing limit has expired, you will be responsible for payment of the claim.

Submit your claims to: SHP, PO Box 91110, Sioux Falls, SD 57109-1110

5.4 Timeframe for Payment of Claims

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

When a Participant receives Emergency or Urgent Care Services from an Out-of-Network and/or Non-Participating Practitioner and/or Providers and payment is to be made according to Plan guidelines, Sanford Health Plan will arrange for direct payment to either the Out-of-Network and/or Non-Participating Practitioner and/or Providers, or the Participant, per Plan policies.

If the Provider refuses direct payment, the Participant will be reimbursed for the Maximum Allowed Amount of the services in accordance with the terms of this Plan and this Summary Plan Description. The Participant will be responsible for any expenses that exceed the Maximum Allowed Amount, 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. Coordination of Benefits (COB)

6.1 Overview

If a Participant 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 Participant's health care by a process called "Coordination of Benefits" so that the same care is not paid for twice. Coordination of Benefits (COB) sets out rules for the order of payment of Covered Charges when two or more plans, including

Medicare/Medicaid/TRICARE, are paying. When a Covered Individual is covered by this Plan and one or more other plans, the plans will

coordinate benefits when a Claim is received. The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to one hundred (100%) percent of the total Allowable Charge

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

- The Participant must tell the Plan about any other plans or insurance that cover health care for the Participant, and
- The Participant must cooperate with the Plan by providing any information requested by SHP. The rest of the provisions under this section explain how COB works.

NOTE: This section does not apply to Outpatient Prescription Drug Benefits.

6.2 Applicability

The Coordination of Benefits (COB) provision, under this Summary Plan Description, applies to this Plan when a Participant or Participant'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 subsection below entitled: "Effect of COB on the Benefits of this Plan."

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 Plan Sponsor. 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.

Some, or all, of the costs of medical care may be the responsibility of an insurance party other than the Plan Sponsor, if the Participant is injured, or become ill, as a result of work-related accidents or environment, and is eligible for benefits under applicable Workers' Compensation Laws. If Workers' Compensation denies all or part of a claim, SHP will review the claim to determine whether to pay any benefits as the secondary carrier.

6.3 Excess Insurance

If at the time of injury, illness, disease, or disability there is available, or potentially available any Coverage (including Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. The Plan's benefits will be excess to, whenever possible:

- a. Any primary payer besides the Plan;
- b. Any first party insurance through medical payment coverage, personal injury protection, No-fault Auto Insurance coverage, uninsured or underinsured motorist coverage;

- c. Any policy of insurance from any insurance company or guarantor of a third party;
- d. Workers' Compensation or other liability insurance company; or
- e. Any other source, including crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Excess insurance is also discussed in Section 7.

6.4 Allowable Charge/Expense

For a charge to be "allowable" it must not exceed the Usual and Customary Rate and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other In-Network only plans: This Plan will not consider any charges in excess of what an HMO or network Health Care Provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Individual does not use an HMO or network Health Care Provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Covered Individual used the services of an HMO or network Health Care Provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge. See definition of "Allowable Expense" below for further information on this provision.

6.5 Automobile Insurance Limitations

When medical payments are available under any vehicle insurance (including no-fault automobile insurance, uninsured motorist coverage, or underinsured motorist coverage), the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles.

This Plan shall always be considered secondary to any such vehicle plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title, or classification.

6.6 Definitions (for COB Purposes Only)

1. **"Plan"** is any of the following which provides benefits or services for, or because of the benefits of another medical or dental care or treatment plan:
 - 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 XIX, 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. 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 Plan, 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 Participant and covered Dependents.
 - a. 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.
 - b. 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.
 - c. When there are more than two (2) plans covering the Participant, 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.
 - a. 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.

- b. An expense or service, or a portion of an expense or service, which is not covered by any of the plans, is not an allowable expense. Expenses not allowable include the following:
 - i. 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 SHP) is not an allowable expense;
 - c. An expense or service, or a portion of an expense or service, which is not covered by any of the plans, is not an allowable expense. Expenses not allowable include the following:
 - i. 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 Sanford Health Plan) is not an allowable expense;
 - ii. If a person is covered by two or more plans (excluding Medicare, Medicaid, or TRICARE; see "Coordination of Benefits with Governmental Plans" 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;
 - iii. If a person is covered by two or more plans (excluding Medicare, Medicaid, or TRICARE; see "Coordination of Benefits with Governmental Plans" 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;
 - iv. 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
 - v. When benefits are reduced under a primary plan because a Participant 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, Prior Authorization 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 over insurance 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 Participants 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 an In-Network Participating Practitioner and/or 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.

6.7 Order of Benefit Determination Rules

- 1. **General.** When two or more plans pay benefits, the following rules apply when determining which health plan will be the primary payer:
 - a. Any plan without a COB provision always pays first.
 - b. Plans with COB provisions will pay their benefits up to the Allowable Charge/Expense, as defined in this Section.
 - c. If a Covered Individual is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.
- 2. The Plan will pay primary to TRICARE and a State child health plan to the extent required by federal law.

3. **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 Participant, (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 Participant, then the order of benefits between the two plans is reversed so that the plan covering the person as a Participant 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 plan of the Participant covering the child whose birthday occurs earlier in the calendar year will be primary (known as the birthday rule).
 1. If both have the same birthday, the policy that has been in effect longer will be primary.
 2. The birthday rule is superseded when a court order or custody rule applies.
 - ii. If both parents have the same birthday, the plan that covered either of the parents longer is primary.
 - iii. 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.
 - iv. If the parents are not married, or are separated (whether or not they have been married) or are divorced, the order of benefits is:
 1. The plan of the custodial parent;
 2. The plan of the Spouse of the custodial parent;
 3. The plan of the noncustodial parent; and then
 4. The plan of the Spouse of the noncustodial parent.
 - c. If the dependent is a child of divorced or separated parents, primary payer status is determined according to the following:
 - i. If the divorce decree places responsibility on one parent, that parent's health plan is primary.
 - ii. Otherwise, the custodial parent's plan is primary and the other parent's health plan becomes secondary.
 - iii. If there is joint custody, the Birthday Rule applies and the health plan of the parent whose birthday occurs earlier in the calendar year is primary.
 - d. **Active/Inactive Participant.** The benefit of a plan that covers a person as a Participant who is neither laid off nor retired (or as that Participant'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 in which benefits are payable, 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 the rules above. The benefits of a benefit plan that covers a person as a non- COBRA beneficiary are determined before those of a plan that covers the person as a COBRA beneficiary.
 - e. **Continuation Coverage.** If a person, whose coverage is provided under a right of continuation, pursuant to a federal is also 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 Participant (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 that covered the Participant longer, is primary.
 - f. **Longer or shorter length of Coverage.** The plan that covered the person as an Employee, Participant, Dependent, or retiree longer is primary.

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.

6.8 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” below.
2. **Reduction in this Plan’s Benefits.** The benefits of this Plan will be reduced when the sum of:
 - a. the benefits that would be payable for the Allowable Expense under this Plan in the absence of this COB provision; and
 - b. 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 the benefits that would have been paid for the Participant under this Plan.
 - c. If a Participant 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.
 - d. 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. SHP has the right to decide which facts it needs. It may get needed facts from or give them to any other organization or person. SHP need not tell, or get the consent of any person to do this. Each person claiming benefits under this Plan must give SHP any facts it needs to pay the claim.
4. **Facility of Payment.** Payment made under another plan may include an amount that should have been paid under this Plan. If it does, SHP may pay that amount to the organization that made that payment. That amount will then be treated as though it was a benefit paid under this Plan. SHP 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 SHP 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.

6.9 Calculation of Benefits, Secondary Plan

If this 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 the Plan, should the Plan wish to coordinate benefits, it shall calculate the benefits the Plan 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.

The Plan may reduce the Plan payment by any amount that, when combined with the amount paid by the primary plan, exceeds the allowable expense the Plan would have paid for that claim.

6.10 Coordination of Benefits with Governmental Plans

After this Plan, Medicare (if applicable), and/or any Medicare Supplementary Insurance (Medigap) have paid claims, then Medicaid and/or TRICARE pay last. The Plan will pay primary to TRICARE and a State Child Health Insurance Plan (SCHIP) to the extent required by federal law.

Coordination of Benefits with Medicare

1. The federal “Medicare Secondary Payer” (MSP) rules require that, for persons covered under both Medicare and a group health plan, Medicare must be the secondary payer in certain situations. This means that the group health plan must not take Medicare entitlement into account when:
 - a. determining whether these individuals are eligible to participate in the Plan; or
 - b. providing benefits under the Plan.
2. Medicare will pay primary, secondary, or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Claims Administrator will make this determination based on the information available through CMS.

When MSP Rules Apply to COB

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

Coordination with Medicare Part D

This Plan shall coordinate information relating to prescription drug coverage, the payment of premiums for the coverage, and the payment for supplemental prescription drug benefits for Part D eligible individuals enrolled in a Medicare Part D plan or any other prescription drug coverage.

The following provisions apply to this Plan’s COB with Medicare:

1. When Medicare is the primary payer for a Participant’s claims:
 - a. If you’re 65, or older, and have group health plan coverage based on your or your spouse/domestic partner’s current employment
 - b. If you have retiree insurance (insurance from former employment)

NOTE: The hospital or doctor will first file claims with Medicare. Once Medicare processes the claim, an Explanation Of Medicare Benefits (EOMB) form will be mailed to the patient explaining what charges were covered by Medicare. Then the health care professional will generally file the claim with us. If a professional does not do so, the Participant may file the claim by sending a copy of the EOMB, together with his or her member identification number, to the address shown on his or her member ID card.
2. When Medicare is primary despite the MSP rules:
 - a. A Medicare-entitled person refuses coverage under this Plan;*
 - b. Medical services or supplies are covered by Medicare but are excluded under the group health plan;
 - c. A Medicare-entitled person has exhausted his or her benefits under the group health plan;
 - d. A person entitled to Medicare for any reason other than ESRD, experiences a COBRA qualifying event, and elects COBRA continuation;
 - e. A person who was on COBRA becomes entitled to Medicare for a reason other than ESRD, and his or her COBRA coverage ends.

* NOTE: Despite the MSP rules, the law does not force an Eligible Employee to accept coverage under this Plan. If an Eligible Employee, who is entitled to Medicare, refuses coverage under this Plan, Medicare will be the primary payer. In this situation, the Plan does not (and is not allowed to) provide coverage for any benefits to supplement the individual’s Medicare benefits.

3. When the Plan is the primary payer for a Participant’s claims:
 - a. If you’re under 65 and disabled, and have coverage under this Plan based on your or a family member’s current employment
 - b. When coverage under the Plan is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA)
 - c. The Participant (actively-working Employee) is enrolled in Medicare because they are age 65 or older.
 - d. A Covered Spouse/domestic partner, who is enrolled in Medicare because they are age 65 or older, regardless of the age of the Participant/Employee. NOTE: The Participant’s claim is filed with us by the

hospital or doctor. After the claim is processed, we send the Participant an Explanation of Benefits (EOB) outlining the charges that were covered. We also notify the health care professionals of the covered charges. If there are remaining charges covered by Medicare, the health care professional may file a claim with Medicare. If the professional will not do so, the Participant can file the claim with Medicare. Participants may contact their local Social Security office to find out where and how to file claims with the appropriate “Medicare intermediary” (a private insurance company that processes Medicare claims).

4. 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 SHP’s allowable expense.
5. Employees who reach age 65 and are still employed at Sanford may remain covered under the Sanford Health Plan. Sanford Health Plan will remain the primary carrier and Medicare will be the secondary carrier. When the Spouse/domestic partner of an Employee reaches the age of 65, they will have the option of selecting Sanford Health Plan or Medicare as their primary insurance carrier.

Participants with End Stage Renal Disease (ESRD)

End-Stage Renal Disease (ESRD) is a medical condition in which a person’s kidneys cease functioning on a permanent basis leading to the need for a regular course of long-term dialysis or a kidney transplant to maintain life. Beneficiaries may become entitled to Medicare based on ESRD. Benefits covered by Medicare, because of ESRD, are for all covered services, not only those related to the kidney failure condition.

The Plan does not differentiate in the benefits it provides to individuals who have ESRD, e.g. terminating coverage, imposing benefit limitations, or charging higher premiums.

How Primary vs. Secondary is Determined:

The Plan will pay first for thirty (30) months after the Member becomes eligible to join Medicare, starting with the first dialysis month or transplant month. This applies regardless of employment status and includes COBRA or retirement plan coverage. After the 30-month coordination period where the Member should enroll in Medicare, Medicare is the primary payer for a Member’s claims under ESRD.

Coordination of Benefits with Medicaid

A Covered Individual’s eligibility for any State Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Individual. Any such benefit payments will be subject to the applicable State’s right to reimbursement for benefits it has paid on behalf of the Covered Individual, as required by such state’s Medicaid program; and the Plan will honor any subrogation rights the State may have with respect to benefits that are payable under the Plan.

When an individual covered by Medicaid also has coverage under this Plan, Medicaid is the payer of last resort. If also covered under Medicare, this Plan pays primary, then Medicare, and Medicaid is tertiary.

See provisions below on Coordination of Benefits with TRICARE, if a Participant is covered by both Medicaid and TRICARE.

Coordination of Benefits with TRICARE

Generally, TRICARE is the secondary payer if the TRICARE beneficiary is enrolled in, or covered by, any other health plan to the extent that the service provided is also covered under the other plan.

1. This Plan pays first if an individual is covered by both TRICARE and this Plan, as either the Participant or Participant’s Dependent; and a particular treatment or procedure is covered under both benefit plans.
2. TRICARE will pay last; TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim.
3. When a TRICARE beneficiary is covered under this Plan, and also entitled to either Medicare or Medicaid, this Plan will be the primary payer, Medicare/Medicaid will be secondary, and TRICARE will be tertiary (last).

4. TRICARE-eligible employees and beneficiaries receive primary coverage under this Plan's provisions in the same manner, and to the same extent, as similarly situated employees of the Plan Sponsor (Employer) who are not TRICARE eligible.

The Plan Sponsor, and its delegated Claims Administrator, SHP, do not:

1. Provide financial or other incentives for a TRICARE-eligible employee not to enroll (or to terminate enrollment) under the Plan, which would (in the case of such enrollment) be a primary plan (the incentive prohibition); and
2. Deprive a TRICARE-eligible employee of the opportunity to elect to participate in this health benefit plan.

6.11 Facility of Payment

This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan. If Medicaid covers a Participant and Medicaid pays benefits that should have paid by this Plan, this Plan will pay those benefits directly to Medicaid.

6.12 Right of Recovery

Whenever payments have been made by this Plan with respect to Allowable Charges in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Section, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine:

1. Any person to or with respect to whom such payments were made, or such person's legal representative;
2. Any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Charges; and
3. Any future benefits payable to the Covered Individual.

Section 7. Subrogation and Right of Reimbursement

7.1 Overview

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

This Plan may give or obtain needed information from another insurer or any other organization or person. Each and every Covered Individual hereby authorizes the Plan to give or obtain any medical or other personal information reasonably necessary to apply the provisions of Sections 6 and 7.

A Covered Individual will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

The Health Plan has a right to reduce benefits, or to be reimbursed for that which it has provided to the Participant. This is called “Reimbursement” and this part of the SPD covers such situations.

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

7.2 Plan’s Rights of Subrogation and Reimbursement

In the event of any payments for benefits provided to a Participant under this Plan, the Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Participant, Participant’s 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 Maximum Allowed Amount for the services provided by the Plan. In providing benefits to a Participant, Sanford Health Plan may obtain discounts from its health care Providers, compensate Providers on a capitated basis or enter into other arrangements under which it pays to another less than the Maximum Allowed Amount of the benefits provided to the Participant. Regardless of any such arrangement, when a Participant receives a benefit under the Plan for an illness or injury, the Plan is subrogated to the Participant’s right to recover the Maximum Allowed Amount of the benefits it provides on account of such illness or injury, even if the Maximum Allowed Amount 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 Participant has been made whole by any recovery. The Plan shall have a lien on all funds received by the Participant, Participant’s parents, heirs, guardians, executors, or other representatives up to the Maximum Allowed Amount charge for any past, present, or future Health Care Services provided to the Participant. 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 Participant’s rights to the extent of the benefits provided or to be provided under this Plan. This includes the Plan’s right to bring suit against the third party in the Participant’s name.

As assignee, the Plan shall recover the first dollar you or your dependent is entitled to receive from any source for you or your dependent’s injury(ies) or Illness(es) up to the amount advanced, regardless of whether you or your dependent is made whole, regardless of whether you or your dependent has been paid for all of his or her claims for damages, and regardless of how the payment is described. The made whole doctrine shall not apply to the Plan’s right of assignment. The Plan’s right of assignment is a right of first reimbursement and takes priority over any person’s interest in such payment. As a result, the Plan shall automatically have a first priority lien upon the proceeds of any recovery you or your dependent receive(s). The Plan’s right of assignment shall not be reduced by any attorney’s fees, court costs, or other expenses incurred by you or your dependent to recover such payments. If the Plan is precluded from exercising its

right of assignment, the Plan may exercise its right of subrogation and/or reimbursement as stated below.

If payments are made under this Plan for any treatment or service because of injury to, or sickness of, a covered individual who has a lawful claim, demand or right against a third party or parties (including an insurance carrier or uninsured motorist coverage) for indemnification, damages or other payment with respect to such injury or sickness, then:

- a. The Plan shall be subrogated, to the extent of the payments made under this Plan, to the rights of the covered individual to receive or claim such indemnification, damages or other payment.
- b. The covered individual and their legal counsel, if any, shall execute or secure the execution of such instruments as the Plan may reasonably require to enforce its rights hereunder; and
- c. Any individual who shall receive payment from any such third party or parties because of injury to, or sickness of, a covered individual shall first reimburse the Plan (before reimbursing any third parties) from such payment so received (but not in excess of the amount received) for all payments made, past, present, and future under this Plan for treatment or service with respect to the same injury or sickness.
- d. Such first reimbursement shall be made to the Plan, without set-off for attorney fees or any other costs or expenses and without regard to whether the covered individual has been “made whole” for his/her damages and the Plan shall hold an automatic first priority lien upon the proceeds of any reimbursement payment or recovery until it receives full reimbursement.
- e. Should the covered individual fail to reimburse the Plan first from any such payment received, the Plan may file suit to recover, and the covered individual will be solely responsible for any court costs in connection with such suit.

The Participant is required to submit a Subrogation Agreement provided by the Plan office which has been signed by the Participant, beneficiary if applicable, and their legal counsel, if any, as a necessary part of Proof of Loss for a claim involving a third party action. Failure to submit such signed agreement may cause payment of the claim to be delayed until the third party action is resolved or disallowed due to failure on the part of the Participant to provide adequate Proof of Loss. The payment of benefits by the Plan without a Subrogation Agreement shall not diminish or nullify the Plan’s rights of subrogation and/or reimbursement.

Under no circumstances will the Plan share in or assume liability for any legal fees or any other costs and expenses incurred by the covered individual in connection with any third party claim, and its rights of Subrogation and First Reimbursement shall not be subject to the “Make Whole” doctrine, or similar doctrine, under state law or federal common law.

If you or your dependent recovers from any source any amount for any injury(ies) or Illness(es) for which the Plan advanced medical payments, you or your dependent shall reimburse the Plan an amount equal to the amount advanced or the amount of you or your dependent’s recovery, whichever is lesser. The Plan shall recover the first dollar you or your dependent is entitled to receive from any source for you or your dependent’s injury(ies) or Illness(es), regardless of whether you or your dependent is made whole, regardless of whether you or your dependent has been paid for all of his or her claims for damages, and regardless of how the payment is described. The make whole doctrine shall not apply to the Plan’s right of reimbursement.

The Plan’s right of reimbursement is a right of first reimbursement and takes priority over any person’s interest in such payment. As a result, the Plan shall automatically have a first priority lien upon the proceeds of any recovery you or your dependent receive(s). The Plan’s right of reimbursement shall not be reduced by any attorney’s fees, court costs, or other expenses incurred by you or your dependent to recover such payments. If the Plan is precluded from exercising our right of reimbursement, the Plan may exercise our right of assignment and/or subrogation.

7.3 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 Participant by or on behalf of a third party who is or may be liable to the Participant, 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.

To the extent that federal statutes, or federal courts, eliminate or restrict any such right of reduction or reimbursement provided to the Plan under this SPD; such rights shall thus either be limited or no longer apply, or be limited by the

extent of federal actions.

The Plan shall have a lien on all funds received by the Participant, Participant's parents, heirs, guardians, executors, or other representatives up to the Maximum Allowed Amount for the Health Care Services provided to the Participant.

7.4 Erroneous Payments

To the extent payments made by this Plan with respect to a Covered Individual are in excess of the Maximum Amount of payment necessary under the terms of the Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following sources, as this Plan shall determine any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are either responsible for payment or received payment in error, and any future benefits payable to the Covered Individual.

7.5 Participant's Responsibilities

1. The Participant, Participant's parents, heirs, guardians, executors, or other representatives must take such action, furnish such information and assistance, and execute such instruments as the Plan requires to facilitate enforcement of its rights under this Part. The Participant shall take no action prejudicing the rights and interests of the Plan under this provision.
2. Neither a Participant nor Participant's 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.
3. Any Participant who fails to cooperate in the Plan's administration of this Part shall be responsible for the Maximum Allowed Amount for services subject to this section and any legal costs incurred by the Plan to enforce its rights under this section. The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Individual if a Covered Individual refuses to cooperate with the Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Covered Individual is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of injury or illness caused by a Third Party until after the Covered Individual or his or her authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first-dollar Subrogation and Refund rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein. The Plan Administrator reserves the right to terminate an individual's eligibility for coverage under this Plan if the individual fails to cooperate.
4. Participants must also report any recoveries from insurance companies or other persons or organizations arising from or relating to an act or omission that caused or contributed to an injury or illness to the Participant paid for by the Plan. Failure to comply will entitle the Plan to withhold benefits, services, payments, or credits due under the Plan.

7.6 Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Individual(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Individual(s), such that the death of the Covered Individual(s), or filing of bankruptcy by the Covered Individual(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

Section 8. How Coverage Ends

8.1 Termination of Participant Coverage

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

1. Premium Payments. Failure to make premium payments when due.
2. Employee Termination. Your benefits will end the last day of the month in which you terminate employment.
3. Plan Termination. The date this Plan terminates.
4. Eligibility. Your benefits will end upon expiration of the period covered by your last contribution.
5. Dependent Eligibility. Benefits for your dependents will end upon expiration of the period covered by your last contribution.
6. Retiree Termination. The last day of the month in which the retiree, or his or her Dependents, become eligible for Medicare.
7. Divorce/Legal Separation or Termination of Domestic Partnership. Coverage for a Dependent Spouse/Domestic Partner will end on the last day of the month in which the date of divorce or legal separation or termination of domestic partnership occurs.
8. Death. The date the Participant dies.
9. Intentional Misrepresentation, Concealment of Material Fact or Fraudulent Information. If your coverage is terminated for these reasons, the Plan Administrator will provide at least thirty (30) days' written notice before the effective date of Rescission to each Participant affected when the Plan determines a Participant has engaged in fraud or made an intentional misrepresentation of material fact under this Summary Plan Description.
10. Use of ID Card by Another. The date a Participant allows another individual to use his or her ID card to obtain services.

Participant Appeal of Termination

Participant may appeal the Plan's decision to terminate, cancel, or refuse to renew the Participant's coverage. The appeal will be considered to be a Participant Appeal under the Plan Sponsor's policy on Participant Appeals, which will govern the Appeal procedure.

Pending the appeal decision, coverage will terminate on the date that was set by the Plan Sponsor. However, the Participant may continue coverage, if entitled to do so, by complying with the process to continue coverage, as outlined in Section 10. If the Plan Sponsor decides the appeal in favor of the Participant, coverage will be reinstated, retroactive to the effective date of termination, as if there had been no lapse in coverage.

NOTE: A Participant may not be terminated due to the status of the Participant's health or because the Participant has exercised his or her rights under the Plan Sponsor's policy on participant appeals or the policy on appeal procedures for medical review determinations.

8.2 Cancellation of This or Previous Benefit Plans

If the Benefit Plan is terminated, modified or amended, coverage is automatically terminated, modified or amended for all enrolled Participants of the Plan. It is the Plan Administrator's responsibility to notify Participants of the termination of coverage.

8.3 Notice of Creditable Coverage

You, the Participant, may request a Certificate of Creditable Coverage for you and your covered family Participants upon your voluntary or involuntary termination from the Plan. You may also request a Certificate of Creditable Coverage at any time by calling Customer Service.

Section 9. Options After Coverage Ends

9.1 Federal Continuation of Coverage Provisions (“COBRA”)

Notice of Continuation Coverage Rights Under COBRA

Introduction

This notice has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review the Plan’s Summary Plan Description or contact SHP.

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse’s plan or domestic partner’s plan), even if that plan generally does not accept late enrollees.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a “Qualifying Event.” Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage will be offered to each person who is a “qualified beneficiary.” You, your spouse/domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you’re an Employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you’re the spouse/domestic partner of an Employee, you’ll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse/domestic partner dies;
- Your spouse/domestic partner’s hours of employment are reduced;
- Your spouse/domestic partner’s employment ends for any reason other than his or her gross misconduct;
- Your spouse/domestic partner becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse or you terminate your domestic partnership with the covered employee.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because of the following qualifying events:

- The parent-Employee dies;
- The parent-Employee’s hours of employment are reduced;
- The parent-Employee’s employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated or domestic partnership is terminated; or

- The child stops being eligible for coverage under the Plan as a “Dependent Child.”

Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to Sanford, and that bankruptcy results in the loss of coverage of any retired Employee covered under the Plan, the retired Employee will become a qualified beneficiary. The retired Employee’s spouse/domestic partner, surviving spouse/domestic partner, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA Continuation Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The employer must notify SHP of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the Employee;
- Commencement of a proceeding in bankruptcy with respect to the employer; or
- The Employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce/legal separation/termination of domestic partnership of the Employee and spouse/domestic partner or a dependent child is losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must provide this notice to your employer or contact SHP’s Customer Service.

How is COBRA Continuation Coverage Provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses/domestic partners, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

1. *Disability extension of 18-month period of COBRA continuation coverage*
If you or anyone in your family covered under the Plan is determined by Social Security to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and will last at least until the end of the 18-month period of COBRA continuation coverage.
2. *Second qualifying event extension of 18-month period of continuation coverage*
If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse/domestic partner and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse/domestic partner and any dependent children getting COBRA continuation coverage if the Employee or former Employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent Child stops being eligible under the Plan as a Dependent Child. This extension is only available if the second qualifying event would have caused the spouse/domestic partner or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children’s Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse/domestic partner’s plan) through what is called a “Special Enrollment Period.” Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Can I enroll in Medicare instead of COBRA continuation coverage after my group health plan coverage ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period¹ to sign up for Medicare Part A or B, beginning on the earlier of

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit <https://www.medicare.gov/medicare-and-you>

If You Have Questions

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act; and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.healthcare.gov.

Keep Your Plan Informed of Address Changes

To protect your family's rights, let the Plan Administrator know about any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Claims Administration Contact Information

Mail: Sanford Health Plan, Customer Service, 4800 W 57th St, Sioux Falls, SD 57109-1110
Phone: (800) 752-5863 (toll-free)
TTY: 711 (toll-free)
Fax: (605) 328-6812

9.2 The Family Medical Leave Act of 1993 (FMLA)

If applicable, FMLA requires covered employers to provide up to twelve (12) weeks of unpaid, job-protected leave to "eligible" Employees for certain family and medical reasons. FMLA also allows an Employee to take up to a total of twenty-six (26) weeks to care for a Spouse, parent, child or "next of kin" who has suffered a serious illness or injury while on active military duty. Employees are eligible if they have worked for a covered employer for at least one (1) year and for 1,250 hours over the previous twelve (12) months, and if there are at least fifty (50) Employees within seventy-five (75) miles. If you are eligible for FMLA leave, you may continue coverage under the Plan by paying employee premiums.

¹ <https://www.medicare.gov/basics/get-started-with-medicare/sign-up/when-does-medicare-coverage-start>.

9.3 The Uniformed Services Employment & Reemployment Rights Act of 1994 (USERRA)

CONTINUATION OF BENEFITS

Effective October 13, 1994 federal law requires that health plans offer to continue coverage for Employees who are absent due to service in the uniformed services and/or their Dependents. Coverage may continue for up to twenty-four (24) months after the date the Employee is first absent due to uniformed service.

ELIGIBILITY

An Employee is eligible for continuation under USERRA if absent from employment because of voluntary or involuntary service, in time of peace or war. USERRA applies to people in the active components of the following uniformed services: Army, Navy, Air Force, Coast Guard and Marine Corps and their reserves; Army and Air National Guards; the commissioned corps of the Public Health Service; and certain types of service in the National Disaster Medical System. Service includes absence for active duty, active or inactive duty for training, initial active duty for training, full-time National Guard duty, examination to determine fitness for duty, funeral honors duty by National Guard or Reserve members; and certain duties performed by National Disaster Medical System Employees.

An Employee's Dependents who have coverage under the Plan immediately prior to the date of the Employee's covered absence are eligible to elect continuation under USERRA.

PREMIUM PAYMENT

If continuation of Plan coverage is elected under USERRA, the Employee or Dependent is responsible for payment of the applicable cost of coverage. If the Employee is absent for no longer than thirty-one (31) days, the cost will be the amount the Employee would otherwise pay for coverage. For absences exceeding thirty-one (31) days, the cost may be up to 102% of the cost of the full premium under the Plan. This includes the Employees share and any portion previously paid by the employer.

DURATION OF COVERAGE

Elected continuation coverage under USERRA will continue for a period that is the shorter of the following two periods:

- Twenty-four (24) months beginning the first day of absence from employment due to service; or
- The period beginning on the date the Employee's absence begins and ending on the date on which the Employee fails to return to the job or apply for reemployment as required by USERRA.

Under federal law, the period of coverage available under USERRA shall run concurrently with the COBRA period available to an Employee and/or eligible Dependents. When the Employee returns to work and meets the reinstatement eligibility criteria as defined by USERRA, the Plan will waive any exclusions and waiting periods, even if the Employee did not elect COBRA continuation.

OTHER INFORMATION

Employees should contact their employer with any questions regarding coverage normally available during a military leave of absence or continuation coverage and notify the employer of any changes in marital status, or a change of address.

Section 10. Problem Resolution

10.1 Participant Appeal and Complaint Procedures – OVERVIEW

SHP 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. Benefits under this Plan will be paid only if SHP decides, at SHP's discretion, that the applicant is entitled to them.

Claims for benefits under the Plan can be post-service, pre-service, or concurrent. This Section of your Summary Plan Description explains how you can file a complaint regarding services provided by the Plan; or appeal a partial or complete denial of a claim. The appeal procedures outlined below are designed to comply with the requirements of the Employee Retirement Income Security Act of 1974 (ERISA).

For information on medication/drug formulary exception requests, see Section 2, subsection "Pharmaceutical Review Requests and Exception to the Formulary Process.

The following parties may request a review of any Adverse Determination by SHP: the Participant and/or legal guardian; a health care Practitioner and/or Provider with knowledge of the Participant's medical condition; an Authorized Representative of the Participant; and/or an attorney representing the Participant or the Participant's estate.

NOTE: The Participant or his/her legal guardian may designate in writing to SHP an Authorized Representative to act on his/her behalf. In cases where the Participant wishes to exercise this right, a written designation of representation from the Participant should accompany a Participant's complaint or request to Appeal an Adverse Determination. See Designating an Authorized Representative below for further details. For urgent (expedited) appeals, written designation of an Authorized Representative is not required.

Special Communication and Language Access Services

For Participants who request language services, the Plan will provide services at no charge in the requested language through an interpreter. Translated documents are also available at no charge to help Participants submit a complaint or appeal, and SHP will communicate with Participants free of charge about their complaint or appeal in the Participant's preferred language, upon request. To get help in a language other than English, call (800) 752-5863.

For Participants who are deaf, hard of hearing, or speech-impaired

To contact SHP, a TTY line is available free of charge by calling toll-free 711.

Designating an Authorized Representative

You must act on your own behalf, or through an Authorized Representative, if you wish to exercise your rights under this Section. If you wish to designate an Authorized Representative, you must do so in writing. You can get a form by calling Customer Service or logging into your account at www.sanfordhealthplan.com/memberlogin. If a person is not properly designated in writing as your Authorized Representative, we will not be able to deal with him or her in connection with your rights under this Section of your Summary Plan Description.

For urgent pre-service claims, we will presume that your provider is your Authorized Representative unless you tell us otherwise, in writing.

Maximum Appeal Timelines			
Type of Notice	Emergency	Pre-Service	Post-Service
Initial Determinations	72 hours	15 days	30 days
Extension for Initial Plan Determinations	NONE	15 days	15 days
Additional Information Request (Plan)	24 hours	15 days	15 days
Response to Request For Additional Information (Member)	48 hours	45 days	45 days
Request for Internal Appeal (Member)	180 days	180 days	180 days
Internal Appeal Determinations	72 hours	30 days	60 days

Request for External Appeal (Member)	N/A	6 months	6 months
External Appeal Determinations	72 hours	45 days	45 days

10.2 Definitions

Adverse Determination: A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment (for pre-service or post-service claims) that is based on:

1. A determination of an individual's eligibility to participate in the Plan;
2. A determination that a benefit is not a Covered Benefit;
3. The imposition of an exclusion, including a network exclusion, application of any utilization review, or other limitation on otherwise covered benefits;
4. A determination that a benefit is Experimental, Investigational or not Medically Necessary or appropriate; or
5. A rescission of coverage. 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 coverage; and deny claims.

Appeal: A request to change a previous Adverse Determination made by SHP.

Inquiry: An oral communication regarding eligibility, plan interpretation, plan policies and procedures, or plan design. It is the policy of SHP to address Participant and Practitioner and/or Provider inquiries through informal resolution orally, 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 an oral or written Complaint.

Complaint (Grievance): Any expression, written or oral, regarding dissatisfaction in how SHP operated or administered services. It is the policy of SHP to make reasonable efforts to resolve Participant and/or Practitioner and/or Provider Complaints. A process has been established for Participants (or their designees) and Practitioners and/or Providers to use when they are dissatisfied with SHP, its Practitioners and/or Providers, or processes. Examples of Complaints are eligibility issues; coverage denials, cancellations, or nonrenewals of coverage; administrative operations; and the quality, timeliness, and appropriateness of health care services provided.

Complainant: This is a Participant, applicant, or former Participant or anyone acting on behalf of a Participant, applicant, or former Participant, who submits a Complaint. The Participant and his/her legal guardian may designate in writing to SHP an Authorized Representative to act on his/her behalf. This written designation of representation from the Participant should accompany the Complaint.

External Review: An External Review is a request for an Independent, External Review of a medical necessity final determination made by Sanford Health through its External Appeals process.

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 Request: 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:

1. Seriously jeopardize the life or health of the Participant or the ability of the Participant 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 Participant's medical condition, subject the Participant 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," SHP shall apply the judgment of a Prudent Layperson as defined in Section 11. A request from a Physician with knowledge of the Participant's medical condition, who determines a request to be "urgent" as defined in Section 11, shall have such a request treated as an Urgent Care Request.

Complaint (Grievance) Procedures

A Participant has the right to file a Complaint either orally or in writing to the Appeals and Grievances Department. The

Appeals and Grievances Department will make every effort to investigate and resolve all Complaints.

Oral Complaints

A complainant may orally submit a Complaint to the Appeals and Grievances Department. If the Complaint is not resolved to the Complainant's satisfaction within ten (10) business days of SHP receiving the oral Complaint, and the Complainant wants SHP to take further action, the Complainant must submit a Complaint in writing to SHP. The Appeals and Grievances Department will notify the Complainant of the requirement for a written Complaint if the Complainant wants to receive Plan investigation findings. Upon request, the Appeals and Grievances Department will provide assistance in submitting Complaint information free of charge.

Written Complaints

A complainant can seek further review of an oral Complaint not resolved by phone by submitting a written Complaint. A Participant, or his/her Authorized Representative, must send the written Complaint, the reasons they believe they are entitled to benefits, and any supporting documentation. Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances Department.

Complaints based on discrimination must be sent to the attention of the Section 504 Coordinator.

A written complaint may also be submitted through the secure communications portal of a Participant's online account at www.sanfordhealthplan.com/memberlogin.

The Appeals and Grievances Department will notify the Complainant within ten (10) business days of receiving a written Complaint, unless the Complaint has been resolved to the Complainant's satisfaction within those ten (10) business days.

Upon request and at no charge, the Complainant will be given reasonable access to and copies of all documents, records and other information relevant to the Complaint.

Written Complaint Investigations

The Appeals and Grievances Department will investigate and review the Complaint and notify the complainant of SHP's decision in accordance with the following timelines:

1. A decision and written notification on the Complaint will be made to the complainant, his or her Practitioners and/or Providers involved in the provision of the service within thirty (30) calendar days from the date SHP receives your request.
2. In certain circumstances, the time period may be extended by up to fourteen (14) days upon agreement. In such cases, SHP will notify the complainant in advance, of the reasons for the extension.
3. Any complaints related to the quality of care received are subject to practitioner review. If the complaint is related to an urgent clinical matter, it will be handled in an expedited manner, and a response will be provided within seventy-two (72) hours.

Unresolved Complaints (Grievances)

If a Complaint is not resolved to the Participant's satisfaction, the Participant, or his/her Authorized Representative, has the right to Appeal any adverse determination made by SHP. Appeal Rights may be requested by calling Customer Service.

All notifications described above will comply with applicable law. A complete description of your Appeal rights and the Appeal process will be included in written responses you receive from SHP.

10.3 Appeal Procedures

Types of Appeals

- A Pre-Service Appeal is a request to change an Adverse Determination that SHP denied, in whole or in part, in advance of the Participant obtaining care or services.
- A Post-Service Appeal is a request to change an Adverse Determination for care or services already received by the Participant.

- An Expedited (Urgent) Appeal is a request to change a previous Adverse Determination made by SHP when services subject to the request are of an urgent or emergent nature.

Continued Coverage for Concurrent Care

A Participant is entitled to continued coverage for concurrent care pending the outcome of the appeals process; benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow the claimant to Appeal and obtain a review determination before the benefit is reduced or terminated. Review determinations would be made within twenty-four (24) hours.

Internal Appeal of Adverse Determination (Denial)

Filing Deadline

Appeals must be made within one hundred eighty (180) days from Participant notification of an Adverse Determination.

Within one hundred eighty (180) days after the date of receipt of a notice of an Adverse Determination sent to a Participant, or the Participant's Authorized Representative, the Participant, or Authorized Representative, may file an Appeal with SHP requesting a review of the Adverse Determination. To ease in the process of filing an Appeal, Participants may use SHP's Appeal Filing Form, which is attached to all SHP Explanation of Benefits (EOB); the form may also be found by logging in to your online account at www.sanfordhealthplan.com/memberlogin. To get a paper copy of the form, contact Customer Service.

To Appeal an Adverse Determination

The Participant, or the Authorized Representative, should contact SHP by calling or sending a written Appeal (using the Appeal Filing Form is optional). Refer to the Introduction section at the beginning of this document for instructions on how to contact the Appeals and Grievances Department.

Written Notification Process for Internal Appeals

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

1. The results and date of the Appeal Determination;
2. The specific reason for the Adverse Determination decision in easily understandable language;
3. The titles and qualifications, including specialty, of the person or persons participating in the internal review process (Reviewer names are available upon request);
4. Reference to the evidence, benefit provision, guideline, protocol, and/or other similar criterion on which the determination was based, and notification that the Participant on request can have a copy of the actual benefit provisions, guidelines, and protocols free of charge;
5. Notification the Participant can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Participant's benefit request;
6. Statement of the reviewer's understanding of the Participant's Appeal;
7. The Reviewer's decision in clear terms and the Summary Plan Description benefit plan basis or medical rationale in sufficient detail for the Participant to respond further;
8. Notification and instructions on how the Practitioner and/or Provider can contact the Physician and/or appropriate Practitioner to discuss the determination;
9. If the Adverse Determination is based on a Medical Necessity, Experimental or Investigational treatment, or a 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 Participant's medical circumstances; or a statement that an explanation will be provided to the Participant free of charge, upon request;
10. If applicable, instructions for requesting:
 - a. Copy of the rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Determination; or
 - b. The written statement of the scientific or clinical rationale for the determination.
11. For Adverse Determinations of Prospective (Pre-Service) or Retrospective (Post-Service) Appeals, a statement

indicating:

- a. The written procedures governing the standard internal appeal, including any required timeframes for receipt of information and SHP's determination; and
 - b. The Participant's right to bring a civil action in a court of competent jurisdiction.
12. A description of a Participant's right to bring civil action under §502(a) of ERISA; and
 13. If the Adverse Determination is completely overturned by the appeal, the decision notice will state the decision and the date.

Internal Appeal Rights and Standard (Non-Urgent) Appeal Procedures

If the Participant or a Participant's authorized representative (as designated in writing by the Participant) files an Appeal for an Adverse Determination, the following Appeal Rights apply:

1. The Participant shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. Participants do not have the right to attend or have a representative attend the review.
2. The Participant shall be provided, free of charge, any new or additional evidence considered, relied upon, or either generated by or at the direction of SHP, in connection with the claim; and such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Determination is required to be provided to give the Participant a reasonable opportunity to respond prior to that date.
3. Confirm with the Participant whether additional information will be provided for appeal review. SHP will document if additional information is provided or no new information is provided for appeal review.
4. Before SHP issues a final Adverse Determination based on any new or additional rationale, the Participant will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Determination is required to be provided, and give the Participant a reasonable opportunity to respond prior to the date.
5. The Participant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Participant's initial request.
6. The review shall take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
7. Full and thorough investigation of the substance of the Appeal, including any aspects of clinical care involved, will be coordinated by the department supervisor.
8. SHP will document the substance of the Appeal, including but not limited to, the Participant's reason for appealing the previous decision and additional clinical or other information provided with the appeal request. SHP will also document any actions taken, including but not limited to, previous denial or appeal history and follow-up activities associated with the denial and conducted before the current appeal.
9. The review shall not afford deference to the initial Adverse Determination; and shall be conducted by a named Plan representative who is neither the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual.
10. In deciding an appeal of any Adverse Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational, or not Medically Necessary or appropriate, SHP shall consult with a health care professional (same-or-similar specialist) who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care Practitioner and/or Provider engaged for purposes of a consultation under this paragraph shall be an individual who is neither an individual who was consulted in connection with the Adverse Determination that is the subject of the appeal, nor the subordinate of any such individual.
11. SHP shall identify the medical or vocational experts whose advice was obtained on behalf of SHP in connection with a Participant's Adverse Determination, without regard to whether the advice was relied upon in making the benefit request determination.
12. In order to ensure the independence and impartiality of the persons involved in making claims determinations and appeals decisions, all decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.

13. The attending Practitioner and/or Provider, and the Participant, will be made aware of their responsibility for submitting any documentation required for resolution of the Appeal within three (3) business (working) days of SHP's request upon receipt of the Appeal.
14. SHP will provide notice of any Adverse Determination in a manner consistent with applicable federal regulations.
15. If the Appeal determination is adverse, the Participant shall be informed of their right to file a civil suit in a court of competent jurisdiction upon completion of the Plan's Appeal procedures.
16. If SHP fails to provide adequate notification of a benefit determination, the 180 day limitation to file an appeal does not apply. If such situation occurs, a Participant should file an Appeal as soon as reasonably possible and the right to file a suit in federal court is not bound by the 180-day filing limitation.

Standard (Non-Urgent) Appeal Notification Timelines

For Pre-service Claim (Prospective) Appeals: SHP will notify the Participant or their Authorized Representative, and any Practitioner and/or Providers involved in the appeal, in writing or electronically of SHP's Internal Appeal determination within thirty (30) calendar days of receipt of Appeal. For initial determination request timelines, see Section 2, How you get care.

For Post-service Claim Appeals: SHP will notify the Participant or their Authorized Representative, and any Practitioner and/or Providers involved in the appeal, in writing or electronically of SHP's Internal Appeal determination within sixty (60) calendar days of receipt of Appeal. For initial determination request timelines, see Section 2, How you get care.

Expedited (Urgent) Appeal Procedure

The procedures in this Section are used for an Expedited (Urgent) Appeal, which is when the Participant's condition is urgent or emergent and an Urgent Care Request is being appealed, as defined in Section 11 of this Summary Plan Description.

An Expedited (Urgent) Appeal for Pre-service or Concurrent claims are utilized if the Participant, or Practitioner and/or Provider acting on behalf of the Participant, believes that an Expedited (Urgent) Appeal is warranted. As described in this Section and in Section 2 (for Benefit and/or Medical Care Determinations), the rights and procedures of a standard internal appeal apply equally to Expedited (Urgent Appeals).

For an Expedited (Urgent) Appeal, the request for an expedited review may be submitted orally or in writing. SHP also accepts all necessary information for Expedited (Urgent) Appeal requests by telephone or electronically. In such situations, the Practitioner who made the initial Adverse Determination may review the appeal and overturn the previous decision.

SHP will notify the parties involved of its expedited appeal determination orally, or in writing, by facsimile or other expedient means. The Participant and those Practitioners and/or Providers involved in the appeal will also receive written notification within three (3) calendar days of the oral notification.

NOTE: If a Participant's claim or appeal is no longer considered or determined to be urgent or emergent, as defined in this Summary Plan Description, it will be handled according to the Standard (Non-urgent) appeal procedures and timelines, depending upon the circumstances. If the expedited review is a Concurrent Review determination, the service will be continued without liability to the Participant until the Participant or the representative has been notified of the determination.

Expedited (Urgent) Appeal Notification Timelines

The determination will be made and provided to the Participant, those Practitioners and/or Providers involved in the expedited appeal request, via oral notification by Utilization Management, as expeditiously as the Participant's medical condition requires, but no later than within seventy-two (72) hours of receipt of the request.

If the information is not received in a timely manner as stated in Section 2, "Utilization Management Review Process", notification will occur as expeditiously as the Participant's medical condition requires, but no later than forty-eight (48) hours after receipt of all the information necessary to process the request for benefits.

External Independent Review of Final Adverse Determination (Denial)

The Plan will follow the procedure for providing independent, external review of final determinations as outlined by federal ERISA regulations and rules governing the Plan in the Patient Protection and Affordable Care Act. Accordingly, an Independent External Review is not available for a Benefit Denial when it does not involve medical judgment.

NOTE: Adverse Benefit Determinations, e.g. denials that do not involve medical/clinical review, are not eligible for an External Review. The Plan's decision on Benefit Determinations is final and binding.

10.4 External Appeal Review Program Procedures

Conduct of the external review program is as follows:

1. Within five (5) business days following the date of receipt of the external review request, SHP shall complete a preliminary review of the request to determine whether:
 - a. The Participant is, or was, a covered person in the Plan at the time the health care service was requested; or in the case of a Retrospective Review, was a covered person in the Plan at the time the health care service was provided;
 - b. The health care service that is the subject of the Adverse Determination is a covered service under the Plan but SHP determined that the health care service is not covered because it does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, or level of care or effectiveness;
 - c. The Participant has exhausted SHP's internal appeal process, unless the Participant is not required to exhaust SHP's internal appeal process as outlined above; and
 - d. The Participant has provided all the information and forms required to proceed with an external review.
2. Within one (1) business day after completion of the preliminary review, SHP shall notify the Participant and, if applicable, the Participant's authorized representative, in writing whether the request is complete and eligible for external review.
 - a. If the request is not complete, SHP shall inform the Participant and, if applicable, the Participant's Authorized Representative, in writing, and include in the notice what information or materials are needed to make the request complete; or
 - b. If the request is not eligible for external review, SHP shall inform the Participant and, if applicable, the Participant's Authorized Representative, in writing, and includes the reasons for its ineligibility.
 - c. If the Independent Review Organization upheld the denial, there is no further review available under this appeals process. However, the Participant may have other remedies available under federal law, such as filing a lawsuit.
3. If the request is complete, within one (1) business day after verifying eligibility, the Plan shall assign an independent review organization and notify in writing the Participant, and, if applicable, the Participant's authorized representative of the request's eligibility and acceptance for external review.
 - a. Within ten (10) business days following the date of receipt of the notice provided by SHP, the Participant may submit, in writing, to the assigned Independent Review Organization, any additional information that the independent review organization shall consider when conducting the external review.
 - b. The independent review organization is not required to, but may, accept and consider additional information submitted after ten (10) business days.
4. Within five (5) business days after the date SHP determines the request is eligible for external review, SHP shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination.
5. SHP contracts with the independent, external review organization that:
 - a. is accredited by a nationally recognized private accrediting entity;
 - b. 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 SHP, or determinations made in any prior Grievance or appeal.
 - c. completes their review and issues a written final decision for non-urgent appeals within forty-five (45)

calendar days of the request.

- d. has no material professional, familial or financial conflict of interest with SHP.
6. For clinically Urgent Care appeals, the review and decision will be made and orally communicated as expeditiously as the Participant's medical condition or circumstances requires, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. Within forty-eight (48) hours after the date of providing the oral notification, the assigned independent review organization will provide written confirmation of the decision to the Participant, or if applicable, the Participant's authorized representative, and their treating Practitioner and/or Provider.
7. With the exception of exercising its rights as party to the appeal, SHP will not attempt to interfere with the Independent Review Organization's proceeding or appeal decision.
8. SHP will provide the Independent Review Organization with all relevant medical records as permitted by applicable laws and regulations, supporting documentation used to render the decision pertaining to the Participant's case (summary description of applicable issues including SHP's decision, criteria used and clinical reasons, utilization management criteria, communication from the Participant to SHP regarding the appeal), and any new information related to the case that has become available since the internal appeal decision.
9. The Participant is not required to bear costs of the Independent Review Organization's review, including any filing fees. However, the Plan is not responsible for Participant's own costs associated with an attorney, physician or other expert, or the costs of travel to an independent, external review hearing.
10. The Participant 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 Participant, unless the appeal is of an urgent nature and qualifies as an Expedited (Urgent) External Review Request.
11. The Independent Review Organization's decision is final and binding to the Plan and SHP implements the Independent Review Organization's decision within the timeframe specified by the Independent Review Organization. The decision is not binding to the Participant, because the Participant has legal rights to pursue further appeals in court if they are dissatisfied with the outcome. However, a Participant may not file a subsequent request for external review involving the same adverse determination for which the Participant has already received an external review decision.

SHP obtains from the Independent 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. SHP 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.

10.5 Standard (Non-Urgent) External Review Request

With the Participant's permission, SHP may refer an appeal directly to an external independent review organization without conducting an internal review.

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

1. Participants the right to an independent, third party, binding review whenever they meet the following eligibility criteria:
 - a. the Participant is appealing an Adverse Determination that is based on medical necessity (Benefit Denials are not eligible);
 - b. the Participant has not appealed to the Federal Department of Labor;
 - c. SHP has either completed its internal appeal review and its decision is unfavorable to the Participant; or SHP has exceeded the time allowed for making a decision; or SHP, with the Participant's permission, has elected to bypass the available internal level of Appeal; and
 - d. the request for independent, external review is filed within four (4) months of the date that SHP's Adverse Determination was made.
2. Notification to Participants about the independent, external appeal program and decision are as follows:
 - a. General communications to Participants, at the same time SHP sends written notice of an Adverse Determination to announce the availability of the right to independent, external review.
 - b. Letters informing Participants 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 Participant 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 Participant and the Plan. The decision will include:
 - i. a general description of the reason for the request for external review, including information sufficient to identify the claim; this information includes the date(s) of service, the provider, claim amount (if applicable), diagnosis and treatment codes (and their corresponding meanings), and the reason for the prior denial;
 - ii. the date the independent review organization received the assignment from SHP to conduct the external review;
 - iii. the date the external review was conducted;
 - iv. the date of its decision;
 - v. the principal reason(s) for its decision, including any, medical necessity rationale or evidence-based standards that were a basis for its decision;
 - vi. the list of titles and qualifications, including specialty, of individuals participating in the appeal review; and
 - vii. a 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.
- c. The external review organization will also notify the Participant how and when Participants receive any payment or service in the case of overturned Adverse Determinations.

10.6 Expedited (Urgent) External Review Request Processes & Procedures

1. A Participant or the Participant's Authorized Representative may request an expedited external review of an adverse determination if the adverse determination involves an Urgent Care requests for Prospective (pre-service) or Concurrent Review request for which:
 - a. the timeframe for completion of a standard internal review would seriously jeopardize the life or health of the Participant; or would jeopardize the Participant's ability to regain maximum function; or
 - b. in the case of a request for Experimental or Investigational services, the treating Practitioner and/or Provider certifies, in writing, that the requested health care services or treatment would be significantly less effective if not promptly initiated.
2. An expedited external review is not provided for Retrospective Adverse Determinations.
3. Immediately upon receipt of the request from the Participant or the Participant's Representative, SHP shall determine whether the request is eligible for Expedited External Review. If the request is ineligible for an Expedited External Review as described in (1) above, SHP will give oral notification to the Participant or the Participant's Representative.
4. Upon determination that the Expedited External Review request meets the reviewability requirements, SHP shall assign a contracted, independent review organization to conduct the expedited external review. The assigned independent review organization is not bound by any decisions or conclusions reached during SHP's utilization review or internal Appeal process.
5. SHP will send all necessary documents and information considered in making the Adverse Determination to the assigned independent review organization electronically, by telephone, or facsimile or any other available expeditious method.
6. The independent review organization will make a decision to uphold or reverse the adverse determination and provide oral notification to the Participant, and, if applicable, the Participant's authorized representative, and the treating Practitioners and/or Providers as expeditiously as the Participant's medical condition or circumstances requires but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review. The Participant and those Practitioners and/or Providers involved in the Appeal will receive written notification within forty-eight (48) hours of the oral notification.
7. At the same time a Participant, or the Participant's authorized representative, files a request for an internal

Expedited Review of an Appeal involving an Adverse Determination, the Participant, or the Participant's authorized representative, may also file a request for an external Expedited External Review if the Participant has a medical condition where the timeframe for completion of an expedited review would seriously jeopardize the life or health of the Participant or would jeopardize their ability to regain maximum function; or if the requested health care service or treatment is Experimental or Investigational and the Participant's treating Practitioner and/or Provider certifies in writing that the recommended or requested health care service or treatment that is the subject of the Adverse Determination would be significantly less effective if not promptly initiated.

8. Upon the Plan's receipt of the independent review organization's decision to reverse the adverse determination, SHP shall immediately approve the coverage that was the subject of the adverse determination.

NOTE: All notifications and procedures described in this Section, in addition to those related to both Benefit and Medical Care Determinations in Section 2, will comply with applicable law. Should a conflict exist between Plan procedures and federal regulations, federal regulations shall control.

A complete description of your Complaint (Grievance) and Appeal Rights and the Appeal process will be included in determination responses and decisions made by SHP. Additionally, an overview of your Complaint and Appeal Rights, along with an Appeal Filing Form, is included in all Explanation of Benefits (EOBs) generated by SHP.

Section 11. Definitions of Terms in this Summary Plan Description

Term	Definition
Admission	Entry into a facility as an Inpatient for treatment and care when ordered by a Health Care Provider with admitting privileges. An Admission ends when a Participant is discharged or released from the facility and is no longer registered as a patient. Also known as Hospitalization.
Adverse Determination	A denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on: 1. A determination of an individual's eligibility to participate in a plan; 2. A determination that a benefit is not a Covered Benefit; 3. The imposition of an exclusion, including a network exclusion, application of any utilization review, or other limitation on otherwise covered benefits; 4. A determination that a benefit is Experimental, Investigational or not Medically Necessary or appropriate; or 5. A rescission of coverage. Does not include a refusal based on nonpayment by a Provider/Practitioner/Pharmacy to provide services.
Allowance or Allowed Charge	The maximum dollar amount that payment for a procedure or service is based on as determined by SHP.
Ambulatory Surgical Center	A lawfully operated, public or private establishment that: a. Has an organized staff of Practitioners; b. Has permanent facilities that are equipped and operated mostly for performing surgery; c. Has continuous Practitioner services and Nursing Services when a patient is in the Facility; and d. Does not have services for an overnight stay.
Amendment	A formal document that changes the provisions of the Plan Document/Summary Plan Description, duly signed by the authorized person or persons as designated by the Plan Sponsor.
Ancillary Services	Ancillary services are services that physicians may request to help diagnose or treat a patient. Ancillary services generally fall into the categories of: • Diagnostic: assist the physician or healthcare provider in diagnosing or detecting an illness or medical condition (e.g., audiology, radiology, clinical laboratory services, pulmonary testing services). • Therapeutic: help to improve the health and well-being of the patient (e.g., speech therapy, physical therapy, occupational therapy, psychotherapy).
Appeal	A request to change a previous Adverse Determination made by SHP.
Approved Clinical Trial	A phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following: 1. A federally funded or approved trial; 2. A clinical trial conducted under an FDA investigational new medication application; or A medication trial that is exempt from the requirement of an FDA investigational new medication application.
Authorized Representative	A person to whom a covered person has given express written consent to represent the Participant, a person authorized by law to provide substituted consent for a Participant, a family member of the Participant or the Participant's treating health care professional if the Participant is unable to provide consent, or a health care professional if the Participant'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 Participant's medical condition.

Term	Definition
Avoidable Hospital Conditions	Conditions that could reasonably have been prevented through application of evidence-based guidelines. These conditions are not present on admission, but present during the course of the stay. Participating Providers are not permitted to bill the Plan or Participants for services related to Avoidable Hospital Conditions.
Beneficiary	Any person designated by a Participant (or by the terms of the Plan under ERISA) who is, or may become, entitled to a benefit under the Plan.
Benefit Period	A specified period of time when benefits are available for Covered Services under this Benefit Plan. A Claim for Benefits will be considered for payment only if the date of service or supply was within the Benefit Period. All benefits are determined on a Calendar Year (January 1st through December 31st) Benefit Period. Also known as Benefit Year.
Benefit Plan	The agreement with SHP, including the Participant's enrollment form, Identification Card, the Benefit Plan Agreement, this Summary Plan Description, the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments
Benefit Year	Period of one year commencing on the effective date (or renewal date) and ending at 11:59 pm on the last day of the benefit year.
Calendar Year	Period of one year, which starts on January 1st and ends December 31st. Period of one year which starts on January 1st and ends December 31st. Calendar Year is also the Benefit Year and/or Benefit Period.
Case Management	A coordinated set of activities conducted for individual patient management of chronic, serious, complicated, protracted, or other health conditions.
Claim for Benefits	Any request for a plan benefit or benefits made by a claimant in accordance with SHP's reasonable procedure for filing benefit claims. Does not include an inquiry as to eligibility, which does not request benefits.
Claims Administrator	SHP
COBRA	The Consolidated Omnibus Budget Reconciliation Act of 1985 and amends to thereafter. COBRA provides for Medical Coverage Continuation for Employees or Dependents who have terminated, divorced/terminated domestic partnership or died (see <i>Options After Coverage Ends</i> in Section 9 for complete details)
Coinsurance Amount	The percentage of charges to be paid by a Participant 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 Hospital Inpatient care, including care at a Residential Treatment Facility, and ongoing outpatient services, including ambulatory care.
Contract Year	A period of one year commencing on the effective date (or renewal date) and ending at 12:00 midnight on the last day of the one year period.
Copayment [Copay]	A specified dollar amount payable by the Participant for certain Covered Services. Health Care Providers may request payment of the Copayment Amount at the time of service.
Cosmetic	Surgery, medication, or other services performed for the primary purpose of enhancing or altering physical appearance without correcting, restoring or improving physiological function, or improving an underlying condition or disease.
Cost Sharing	The share of costs covered by your insurance that you pay out of your own pocket. This term generally includes coinsurance, copayments, or similar charges, but it does not include premiums, balance-billing amounts for non- network providers, or the cost of Non-Covered services.
Covered Services	Those Health Care Services to which a Participant is entitled under the terms of this Plan.

Term	Definition
Creditable Coverage	Benefits or coverage provided under: 1. A group health benefit plan; 2. A health benefit plan; 3. Medicare or Medicaid; 4. A health plan offered under 5 U.S.C. 89; 5. A medical care program of the Indian Health Service or of a tribal organization; 6. A state health benefits risk pool; 7. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government; 8. A health benefit plan under §5(e) of the Peace Corps Act Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e); 9. A state's children's health insurance program funded through Title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].
Custodial Care	Care designed to assist the patient in meeting the activities of daily living and not primarily provided for its therapeutic value in the treatment of an illness, disease, injury or condition.
Deductible	The amount that a Participant must pay each Calendar Year before the Plan begins to pay the costs or provide benefits for Covered Services. The following amounts will not apply towards the deductible: 1. Copayments; 2. Amounts for services that are not medically necessary; 3. Amounts for Non-Covered Services as defined by this SPD; 4. Any difference between the covered charges and the Maximum Allowed Amount if you receive services from a Non-Participating and/or Out-of-Network Provider; and 5. Amounts for services that are not properly Prior Authorized. Out-of-Network charges incurred by a Participant. There is no coverage Out-of-Network unless it is an emergency or urgent care situation.
Dependent	The Spouse/Domestic Partner and any Dependent Child/Domestic Partner's Dependent Child of a Participant.
Dependent Child	A child of the Participant or the Participant's Covered Spouse/Domestic Partner, who is a biological child; a child placed for adoption; a legally adopted child; a child for whom the Participant, or the Participant's Covered Spouse/Domestic Partner, has legal guardianship; a stepchild; or a foster child of a Participant or Participant's Covered Spouse/Domestic Partner; and meets one of the following requirements: 1. under age twenty-six (26); <u>or</u> incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Participant for support and maintenance. If the Plan so requests, the Participant must provide proof of the child's disability within <i>thirty (30)</i> days of the Plan's request.
Domestic Partner	A person in a domestic partnership with an employee.
Domestic Partnership	A committed relationship between two adults, of the opposite sex or same sex, in which the partners: 1. are each other's sole domestic partner and intend to remain so indefinitely; 2. maintain a common residence, and intend to continue to do so (or would maintain a common residence but for an assignment abroad or other employment-related, financial, or similar obstacle); 3. are at least 18 years of age and mentally competent to consent to a contract; 4. share responsibility for a significant measure of each other's financial obligations; 5. are not married or joined in a civil union to anyone else; 6. are not a domestic partner of anyone else; 7. are not related in a way that would prohibit legal marriage in the U.S. jurisdiction in which the partnership was formed; 8. provide documentation demonstrating fulfillment of these requirements; and 9. certify that they understand that willful falsification of the documentation required to establish that an individual is in a domestic partnership may lead to disciplinary action and the recovery of the cost of benefits received related to such falsification and may constitute a criminal violation under 18 U.S.C. § 1001.

Term	Definition
Domiciliary Care	Domiciliary Care consists of a protected situation in a community or Facility, which includes room, board, and personal services for individuals who cannot live independently yet do not require a 24-hour Facility or nursing care.
Eligible Dependent	Any “Dependent” who meets the specific eligibility requirements of the Plan as listed in this Summary Plan Description and under applicable federal laws and rules.
Eligible Employee	Any Employee who meets the specific eligibility requirements of the Plan Sponsor.
Emergency Care Services	Means either: 1. <u>Within the Service Area</u> : covered Health Care Services rendered by Participating or Non-participating Providers under unforeseen conditions that require immediate medical attention, including covered Health Care Services from Non-participating and/or Out-of-Network Providers only when delay in receiving care from In- Network Participating Providers could reasonably be expected to cause severe jeopardy to the Participant’s condition; or <u>Outside the Service Area</u> : Medically Necessary Health Care Services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of SHP’s Service Area. There is no coverage for non-Emergency or non-Urgent care received Out-of-Network.
Emergency Medical Condition	Sudden and unexpected onset of a health condition that, based on a Prudent Layperson’s judgment, 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.
Employee	A person directly involved in the regular business of, and compensated for, services by the Plan Sponsor. ‘Employee’ includes full-time Employees (those who average 30 or more hours per week).
Employer	The Employer, who has allowed its Eligible Employees, their Eligible Dependents, and any other person or party pursuant to the Employer’s eligibility policy, to participate in the Plan by acting as the Plan Sponsor.
Encounter	Any type of initiated contact between a member and provider via a qualified telehealth technology platform.
Enrollee	An individual who is covered by this Plan. An Enrollee is also a Participant.
ERISA	The Employee Retirement Income Security Act of 1974, or any provision or section thereof, as amended from time to time.
ESRD	The federal End Stage Renal Disease program.
Expedited Appeal	An expedited review involving Urgent Care Requests for Adverse Determinations of Prospective (Pre-service) or Concurrent Reviews will be utilized if the Participant, or Practitioner and/or Provider acting on behalf of the Participant, believes that an expedited determination is warranted.
Experimental or Investigational Services	Health Care Services where the Health Care Service in question either: 1. 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 requires approval by any governmental authority and such approval has not been granted prior to the service being rendered.
Facility	An institution providing Health Care Services or a health care setting, including Hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, Skilled Nursing Facilities, Residential Treatment Facilities, diagnostic, laboratory, and imaging centers, and rehabilitation, and other therapeutic health settings.
Formulary	A list of prescription medication products, which are preferred by the Plan for dispensing to Participants when appropriate. This list is subject to periodic review and modifications. Additional medications may be added or removed from the Formulary throughout the year.
Grievance	A written complaint submitted in accordance with SHP’s formal grievance procedure by or on behalf of the enrollee regarding any aspect of the Plan relative to the Participant.
[The] Group or [This] Group	Sanford.
Health Care Services	Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease.

Term	Definition
Hospital	A short-term, acute care, duly licensed institution that is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians. It has organized departments of medicine and/or major surgery and provides 24-hour nursing service by or under the supervision of registered nurses. The term “Hospital” specifically excludes rest homes, places that are primarily for the care of convalescents, nursing homes, skilled nursing facilities, Residential Care Facilities, custodial care homes, intermediate care facilities, health resorts, clinics, Practitioner and/or Provider’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 because 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.
In-Network Benefit Level	The upper level of benefits provided by Sanford Health Plan, as defined in the Summary of Benefits and SPD, when a Participant seeks services from a Participating Practitioner and/or Provider designated by Sanford Health Plan, in its sole discretion, as part of this SPD’s defined network.
In-Network Facility	A Facility (as defined above) considered “In-Network” by the terms of this SPD.
In-Network Pharmacy	A Pharmacy considered “In-Network” by the terms of this SPD.
In-Network Participating Practitioner and/or Provider	A Participating Practitioner and/or Provider that is considered “In-Network” by the terms of this SPD.
Intensive Outpatient Program (IOP)	Provides mental health and/or substance use disorder outpatient treatment services during which a Participant remains in the program a minimum of three (3) continuous hours per day and does not remain in the program overnight. Programs may be available in the evenings or weekends.
Intermediate Care	Care in a licensed/regulator Facility, corporation or association for the accommodation of persons, who, because of incapacitating infirmities, require minimum, but continuous, care; however, such persons are not in need of continuous medical or nursing services. The term also includes facilities for the nonresident care of elderly individuals and others who are able to live independently but who require care during the day.
Late Enrollee	An Eligible Employee or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage. Late Enrollees may not enroll at any time during the year, only during the next scheduled Open Enrollment Period. A Participant is not a Late Enrollee if special enrollment rights apply, as described in Section 2.
Long-Term Residential Care	The provision of long-term diagnostic or therapeutic services (i.e., assistance or supervision in managing basic day-to-day activities and responsibilities) to Participants with physical, mental health and/or substance use disorders. Care may be provided in a long-term residential environment known as a transitional living Facility; on an individual, group, and/or family basis; generally provided for persons with a lifelong disabling condition(s) that prevents independent living for an indefinite amount of time.
Maintenance Care	Treatment provided to a Participant whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Health Care Provider.
Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for covered services and supplies. Sanford Health Plan’s Maximum Allowed amount is the lesser of: (a) the amount charged for a covered service or supply; or (b) inside Sanford Health Plan’s service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or (c) outside of Sanford Health Plan’s service area, using current publicly available data adjusted for geographical differences where applicable: i. Fees typically reimbursed to providers for same or similar professionals; or Costs for facilities providing the same or similar services, plus a margin factor.

Term	Definition
Medically Necessary or Medical Necessity	Health Care Services that are appropriate and necessary as determined by any Participating Provider, in terms of type, frequency, level, setting, and duration, according to the Participant's diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must be consistent with generally accepted standards of medical practice as recognized by SHP, 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; <u>and</u> : a. help restore or maintain the Participant's health; or b. prevent deterioration of the Participant's condition; or c. prevent the reasonably likely onset of a health problem or detect an incipient problem; or not considered Experimental or Investigative
Mental Health and/or Substance Use Disorder Services	Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), and the International Classification of Diseases (ICD), current editions. Also referred to as behavioral health, psychiatric, chemical dependency, substance abuse, and/or addiction services.
Natural Teeth	Original teeth, which are whole and without impairment and are not in need of the treatment provided for reasons other than dental injury; does not include prosthetic teeth, dentures, implants, or bridges.
Never Event	Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a problem in the safety and credibility of a health care Facility. Participating Providers are not permitted to bill the Plan or Participants for services related to Never Events.
Non-Covered Services	Those Health Care Services to which a Participant is not entitled and are not part of the benefits paid under the terms of this Plan.
Non-Participating Practitioner and/or Provider	A Practitioner and/or Provider who does not have a contractual relationship with Sanford Health Plan, directly or indirectly, and not approved by Sanford Health Plan to provide Health Care Services to Participants with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, from Sanford Health Plan.
Non-Payable Health Care Provider	A Health Care Provider that is not reimbursable by SHP. No benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of a Non-Payable Health Care Provider.
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 Participant's immediate family.
Open Enrollment	A period of time at least once a year when Eligible Employees may enroll themselves and their Dependents in the Plan. Annual Enrollment does not pertain to non-Medicare retirees.
Out-of-Network Benefit Level	The lower level of benefits provided by Sanford Health Plan, as defined in the Summary of Benefits and Coverage, when a Participant seeks services from a Non-Participating Practitioner and/or Provider or a Participating Practitioner and/or Provider not designated in the network as defined by the terms of this SPD.
Out-of-Network Participating Practitioner and/or Provider	A Participating Practitioner and/or Provider that is considered "Out-of-Network" by the terms of this SPD.
Out-of-Pocket Maximum Amount	The total of the Participant's Deductible and Cost Sharing Amounts for certain Covered Services that are a Participant's responsibility during a Benefit Period. When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Covered Services for the remainder of the Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period.
Partial Hospitalization	Also known as day treatment; A licensed or approved day or evening outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for individuals with mental health and/or substance use disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment.
Participant	Any employee or former employee who is eligible (or may become eligible) to receive any benefit under this Plan, or whose beneficiaries may be eligible to receive any such benefit. Former employees, like retirees or COBRA qualified beneficiaries, are Participants if they are entitled to benefits under this Plan.

Term	Definition
Participating Practitioner and/or Provider	A Practitioner and/or Provider who, under a contract with Sanford Health Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Participants with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, directly or indirectly, from Sanford Health Plan.
Physician	An individual licensed to practice medicine or osteopathy.
Plan Administrator	The person or entity named by your Plan Sponsor to manage the Plan and answer questions about Plan details.
[The] Plan Sponsor	The self-funded health and welfare benefit plan under which coverage is provided to Participants by the Plan Sponsor (employer group).
Practitioner	A professional who provides health care services. Practitioners are usually required to be licensed as required by law. Practitioners are also Physicians.
Preauthorization [or Certification]	The process of the Participant or the Participant's representative notifying SHP to request approval for specified services. Eligibility for benefits for services requiring Preauthorization is contingent upon compliance with the provisions in Section 3 and 4. Preauthorization does not guarantee payment of benefits. Also known as "Certification."
Premium	The amount paid by the Participant to the Plan Sponsor on a monthly basis for the Plan to provide coverage for Participants under this Plan. Premium is also the amount paid by the Plan Sponsor to cover Plan expenses and claims for coverage for Participants under this Plan.
Pre-service claim	Must involve mandatory preauthorization/certification. Does not include a request for pre-approval of a benefit under this Plan when such benefit does not require preauthorization/certification.
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 SHP.
Primary Care Practitioner and/or Provider (PCP)	A Participating Practitioner and/or Provider who is an internist, family practice Physician, pediatrician, or obstetrician/gynecologist, who is a Participating Practitioner, and who has been chosen to be designated as a Primary Care Practitioner and/or Provider as indicated in the Provider Directory and may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Participant.
Prospective (Pre- service) Review	Means Urgent and non-Urgent Utilization Review conducted prior to an admission or the provision of services, including courses of treatment.
[Health Care] Provider	An individual, institution or organization that provides services for Plan Participants. Examples of Providers include but are not limited to Hospitals, Physicians, Practitioners and/or Providers, and home health agencies.
Prudent Layperson	A person who is without medical training and who possess an average knowledge of health and medicine and who draws on his/her practical experience when making a decision regarding the need to seek Emergency medical treatment.
Qualified Mental Health Professional	A licensed Physician who is a psychiatrist; a licensed clinical psychologist who is qualified for listing on the national register of health service providers in psychology; a licensed certified social worker who is a board- certified in clinical social work; or a nurse who holds advanced licensure in psychiatric nursing
Rescission	A cancellation or discontinuance of coverage, including any benefits paid, that has a retroactive effect of voiding coverage under this Plan, or any benefits paid under the terms of this Plan.

Term	Definition
Residential Treatment Facility	An inpatient mental health or substance use disorder treatment Facility that provides twenty-four (24) hour availability of qualified medical staff for psychiatric, substance abuse, and other therapeutic and clinically informed services to individuals whose immediate treatment needs require a structured twenty-four (24) hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, substance abuse education/counseling. Facilities must be under the direction of a board-eligible or certified psychiatrist, with appropriate staffing on-site at all times. If the Facility provides services to children and adolescents, it must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children. Hospital licensure is required if the treatment is Hospital-based. The treatment Facility must be licensed by the state in which it operates.
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 of payment. Retrospective (Post-service) Review will be utilized by SHP to review services that have already been utilized.
Serious Reportable Event	An event that results in a physical or mental impairment that substantially limits one or more major life activities of a Participant or a loss of bodily function, if the impairment or loss lasts more than seven (7) days or is still present at the time of discharge from an inpatient health care Facility. Serious events also include loss of a body part and death. Participating Providers are not permitted to bill Participants or the Plan for services related to Serious Reportable Events.
Service Agreement	The contract between the Plan Sponsor and SHP to provide administrative services, process claims, and perform preauthorization and/or utilization review processes for Participants under this Plan.
SHP	The geographic Service Area as defined by Sanford Health Plan in the Introduction of this SPD.
Service Area	The geographic Service Area as defined by SHP in the Introduction of this Summary Plan Description.
Skilled Nursing Facility	A Facility that is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly licensed Physician, and such facility is licensed in the state in which it operates.
Spouse	An individual who is legally married to a Participant. The term “Spouse” does not include individuals in common- law marriages or those individuals in domestic partnerships. The sexual orientation, sex, gender, and/or gender identity of Spouses is not a factor in benefit or eligibility determinations.
Summary Plan Description (SPD)	A document describing the essential features, services, and limitations for coverage available to the Participant under this Plan.
TRICARE [or CHAMPUS]	A U.S. Military program that provides coverage for health care services.
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 which: 1. Could seriously jeopardize the life or health of the Participant or the ability of the Participant 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 Participant’s medical condition, would subject the Participant to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
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 <i>twenty-four (24)</i> hours, such as stitches for a cut finger.
Utilization Review	A set of formal techniques used by SHP 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.

Term	Definition
You/Your	The Participant as shown by context.