North Dakota Public Employees Retirement System (NDPERS)

Certificate of Insurance

Dakota Plan Grandfathered PPO/Basic

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Plan on the best fit.

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NORTH DAKOTA PUBLIC EMPLOYEES RETIREMENT SYSTEM DAKOTA PLAN

SANFORD HEALTH PLAN

Notice

Your employer has established an employee welfare benefit plan for Eligible Employees and their Eligible Dependents. The following Summary Plan Description/Certificate of Insurance (Certificate) is provided to you in accordance with the Employee Retirement Income Security Act of 1974. Every attempt has been made to provide concise and accurate information.

This COI and the NDPERS Service Agreement are the official benefit plan documents for the employee welfare benefit plan established by the Plan Administrator. In case of conflict between this Certificate of Insurance/Summary Plan Description and the NDPERS Service Agreement, the provisions of the NDPERS Service Agreement will control.

Although it is the intention of the Plan Administrator to continue the employee welfare benefit plan for an indefinite period of time, the Plan Administrator reserves the right, whether in an individual case or in general, to eliminate the Benefit Plan.

Sanford Health Plan shall construe and interpret the provisions of the Service Agreement, the Certificate and related documents, including doubtful or disputed terms; and to conduct any and all reviews of claims denied in whole or in part. NDPERS shall determine all questions of eligibility.

Plan Name

North Dakota Public Employees Retirement System Dakota Plan

Name and Address of Employer (Plan Sponsor)

North Dakota Public Employees Retirement System
400 East Broadway, Suite 505
PO Box 1657
Bismarck, ND 58502

Plan Sponsor's IRS Employer Identification Number

45-0282090

Plan Number Assigned By the Plan Sponsor

N/A

Type of Welfare Plan

Health

Type of Administration

This employee welfare benefit plan is fully insured by Sanford Health Plan and issued by Sanford Health Plan. Sanford Health Plan is the Claims Administrator for this employee welfare benefit plan.

Name and Address of Sanford Health Plan

Sanford Health Plan
300 Cherapa Place, Suite 201
Sioux Falls, SD 57103
(877) 305-5463 *(toll-free)*
TTY/TDD: (877) 652-1844 *(toll-free)*

Plan Administrator's Name, Business Address and Business Telephone Number

North Dakota Public Employees Retirement System
400 East Broadway, Suite 505
PO Box 1657
Bismarck, ND 58502
(701) 328-3900

Name and Address of Agent for Service of Legal Process

Plan Administrator	Sanford Health Plan
Sparb Collins, Executive Director North Dakota Public Employees Retirement System 400 East Broadway, Suite 505 PO Box 1657 Bismarck, ND 58502	Ruth A. Krystopolski, President Sanford Health Plan 300 Cherapa Place, Suite 201 PO Box 91110 Sioux Falls, SD 57109-1110

Service of legal process may be made upon a Plan trustee or the Plan Administrator.

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Title of Employees Authorized To Receive Protected Health Information

- Administrative Services Division
- Accounting & IT Division
- Accounting Division
- Benefit Programs Division
- Benefit Program Development & Research
- Executive Director
- Internal Audit Division

This includes every employee, class of employees, or other workforce person under control of the Plan Sponsor who may receive the Member'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.

These identified individuals will have access to the Member's Protected Health Information only to perform the plan administrative functions the Plan Sponsor provides to the Benefit Plan. Such individuals will be subject to disciplinary action for any use or disclosure of the Member's Protected Health Information in breach or in violation of, or noncompliance with, the privacy provisions of the Benefit Plan. The Plan Sponsor 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 Member whose privacy may have been compromised.

Statement of Eligibility to Receive Benefits

As provided in N.D.C.C. §54-52.1-01(4), individuals eligible to receive benefits are every permanent employee who is employed by a governmental unit, as that term is defined in N.D.C.C. §54-52-01, whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1,2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. An eligible employee includes members of the Legislative Assembly, judges of the Supreme Court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by N.D.C.C. §54-06-01(2), and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund.

A temporary employee employed before August 1, 2007, may elect to participate in the uniform group insurance program by completing the necessary enrollment forms and qualifying under the medical underwriting requirements of the program if such election is made before January 1, 2015, and if the temporary employee is participating in the uniform group insurance program on January 1, 2015. In order for a temporary employee employed after July 31, 2007, to qualify to participate in the uniform group insurance program, the employee must be employed at least twenty hours per week; must be employed at least twenty weeks each year of employment; must make the election to participate before January 1, 2015; and must be participating in the uniform group insurance program as of January 1, 2015. To be eligible to participate in the uniform group insurance program, a temporary employee first employed after December 31, 2014, or any temporary employee not participating in the uniform group insurance program as of January 1, 2015, must meet the definition of a full-time employee under §4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)].

An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment or eligibility for a special enrollment period as set forth in N.D.A.C. §71-03-03. Each eligible employee may elect to enroll his/her Eligible Dependents.

Eligible employees also include non-Medicare eligible retired and terminated employees, and their Eligible Dependents, who remain eligible to participate in the uniform group insurance program pursuant to applicable state law, as provided in N.D.C.C. §54-52.1-03 and federal regulations. For a comprehensive description of eligibility, refer to the NDPERS web site at www.nd.gov/ndpers.

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan Administrator. When an eligible employee meets the criteria for eligibility, a membership application must be completed. NDPERS has the ultimate decision making authority regarding eligibility to receive benefits.

Description of Benefits

See the Schedule of Benefits in Section 1 and the Covered Services in Section 5. Refer to the Table of Contents for page numbers.

Sources of Premium Contributions to the Plan and the Method by Which the Amount of Contribution Is Calculated

The contributions for single or family for state employees are paid at 100% by the State.

The contributions for employees of participating political subdivisions are at the discretion of the subdivision and subject to the minimum contribution requirements and participation requirements of Sanford Health Plan. Either the contributions for temporary employees are at their own expense or their employer may pay the premium subject to its budget authority.

End of the Year Date for Purposes of Maintaining the Plan's Fiscal Records

June 30

Clerical Error

Any clerical error by either the Plan or Claims Administrators, or the aforementioned entities' designees, 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.

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If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, Sanford Health Plan and NDPERS retain contractual rights to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money.

Recovery of Benefit Payments

Pursuant to N.D.A.C. §71-03-05-06, whenever benefits are paid in noncompliance with the Contract, NDPERS, which is the Plan Administrator, or an agent of the Plan Administrator, retains the right to recover the payments from the party responsible.

If Sanford Health Plan, which is the Claims Administrator and Payor, or an agent of Sanford Health Plan, is at fault, the amount of overpayment will be withheld from the administrative fees paid by NDPERS.

If overpayments are made because of false or misleading information provided by a Member, Sanford Health Plan, or an agent of Sanford Health Plan, shall attempt to recover the amount. Any moneys recovered shall be credited to NDPERS.

If an overpayment is made because of a mistake or deliberate act by a Health Care Provider, Sanford Health Plan shall collect the money from the Provider and credit that amount to NDPERS.

If fraud is suspected, Sanford Health Plan shall inform NDPERS and NDPERS may turn the evidence over to the North Dakota State's Attorney or Attorney General's office for possible prosecution.

Amending and Terminating this Benefit Plan

As Plan Administrator, NDPERS has delegated responsibility for determinations regarding covered benefits, and the amount and manner of the payment of benefits, including the appeal of denied claims, to Sanford Health Plan, the insurer of the plan.

NDPERS reserves the right to terminate the plan, or amend or eliminate benefits under the North Dakota Public Employees Retirement System Dakota Plan, as insured and issued by Sanford Health Plan, at any time and at its discretion, upon mutual agreement between NDPERS and Sanford Health Plan. Should this Benefit Plan be amended or terminated, such action shall be by a written instrument duly adopted by both NDPERS and Sanford Health Plan, or the aforementioned entities' designees.

Summary Notice and Important Phone Numbers

This Certificate describes in detail your Employer's health care Benefit Plan and governs the Plan's coverage. This Certificate, any amendments, and related documents comprise the entire Plan between the Employer and the Claims Administrator.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate carefully. If you have any questions about the benefits, please contact Sanford Health Plan's Member Services.

This Certificate describes in detail the Covered Services provisions and other terms and conditions of the Plan.

Physical Address	**Mailing Address**
Sanford Health Plan 300 Cherapa Place, Suite 201 Sioux Falls, SD 57103	Sanford Health Plan PO Box 91110 Sioux Falls, SD 57109-1110
Member Services	**Preauthorization/Prior Approval**
1-800-499-3416 *(toll-free)* or TTY/TDD: 1-877-652-1844 *(toll-free)*	The Hospital, your Provider, or you should call *(toll-free)*: 1-888-315-0885 or TTY/TDD: 1-877-652-1844
Sanford Health Plan Physician Locator	**Website**
If you need to locate a provider in your area, call (toll-free): 1-800-499-3416 or TTY/TDD: 1-877-652-1844	www.sanfordhealthplan.com/ndpers

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Notice of Privacy Practices

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

This Notice applies to Sanford Health Plan. If you have questions about this Notice, please contact Member Services at 1-800-499-3416 *(toll-free)* | TTY/TDD 1-877-652-1844 *(toll-free)*. You may also email your questions to memberservices@sanfordhealth.org.

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 Sanford Health Plan, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways.

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 health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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 state or federal law 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 a 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 Sanford Health Plan services that may be of interest to you.
- **Fundraising:** We may contact you about fundraising activities, but you can tell us not to contact you again.

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'll tell you why in writing. These requests should be submitted in writing to the contact listed below.

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- **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've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six (6) years prior, who we've 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.

  Contact Information:
  Sanford Health Plan
  ATTN: NDPERS/Member Services
  PO Box 91110
  Sioux Falls, SD 57109-1110
  Phone: 1-800-499-3416 *(toll-free)*
  TTY/TDD: 1-877-652-1844 *(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.

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 www.sanfordhealthplan.com.

EFFECTIVE DATE

This Notice of Privacy Practices is effective September 23, 2013.

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT FOR Sanford Health Plan

Sanford Health Plan and Sanford Health Plan of Minnesota have agreed, as permitted by law, to share your health information among themselves for the purposes of treatment, payment, or health care operations. This notice is being provided to you as a supplement to the above Notice of Privacy Practices.

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Introduction

Member Rights

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

1. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; national origin; gender; age; sexual orientation; medical condition, including current or past history of a mental health and/or substance use disorder; disability; religious beliefs; or sources of payment for care.
2. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
3. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. Members have the right, but are not required, to select a Primary Care Practitioner and/or Provider (PCP) of their choice. If a Member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
5. Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable North Dakota law.
6. Members have the right to know the identity and professional status of individuals providing service to them and to know which Physician or other Provider is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
7. Members have the right to a candid discussion with the Practitioners and/or Providers responsible for coordinating appropriate or medically necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with Practitioners and/or Providers in decision making regarding their treatment plan.
8. Members have the right to give informed consent before the start of any procedure or treatment.
9. When Members do not speak or understand the predominant language of the community, the Plan will make reasonable efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
10. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and easy to read.
11. Members have the right to a clear Grievance and Appeal process for complaints and comments and to have their issues resolved in a timely manner.
12. Members have the right to Appeal any decision regarding medical necessity made by the Plan and its Practitioners and/or Providers.
13. Members have the right to terminate from the Plan, in accordance with Employer and/or Plan guidelines.
14. Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
15. Members have the right to receive information about the organization, its services, its Practitioners and Providers and Members' rights and responsibilities.

Member Responsibilities

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

1. Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible Practitioner. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
2. Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when telephoning or contacting the Plan.
3. Members are responsible for following all access and availability procedures.
4. Members are responsible for seeking Emergency care at a Plan participating Emergency Facility whenever possible. In the event an ambulance is used, direct the ambulance to the nearest participating Emergency Facility unless the condition is so severe that you must use the nearest Emergency Facility. State law requires that the ambulance transport you to the Hospital of your choice unless that transport puts you at serious risk.
5. Members are responsible for notifying the Plan of an Emergency admission as soon as reasonably possible and no later than forty-eight (48) hours after becoming physically or mentally able to give notice.
6. Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible Practitioner or the Hospital.
7. Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating, to the degree possible, in understanding their health care problems including behavioral problems and developing mutually agreed-upon treatment goals.
8. Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
9. Members are responsible for notifying NDPERS within *thirty-one (31)* days if they change their name, address, or telephone number.
10. Members are responsible for notifying NDPERS of any changes of eligibility that may affect their membership or access to services. The employer is responsible for notifying the Plan.

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Disclosure of Grandfathered Status

This employer group health plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits; and requirements under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA).

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan, and what might cause a plan to change from grandfathered health plan status can be directed to Sanford Health Plan at memberservices@sanfordhealth.org. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. The Department of Labor website has a table summarizing which protections do and do not apply to grandfathered health plans.

Fraud

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

As a Member, 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 Sanford Health Plan 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 or Explanation of Benefits form, or if you know of or suspect any illegal activity, call Sanford Health Plan toll-free at 1-800-499-3416. All calls are strictly confidential.

Service Area

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

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

The Service Area for **IOWA** includes the following counties:

Clay	Emmet	Lyon	Osceola	Plymouth
Dickinson	Ida	O'Brien	Sioux	Woodbury

The Service Area for **MINNESOTA** includes the following counties:

Becker	Clay	Jackson	Lincoln	Meeker	Pennington	Renville	Swift
Beltrami	Clearwater	Kandiyohi	Lyon	Murray	Pipestone	Rock	Traverse
Big Stone	Cottonwood	Kittson	Mahnomen	Nicollet	Polk	Roseau	Wilkin
Blue Earth	Douglas	Lac Qui Parle	Marshall	Nobles	Pope	Sibley	Watonwan
Brown	Grant	Lake of the	Martin	Norman	Red Lake	Stearns	Yellow Medicine
Chippewa	Hubbard	Woods	McLeod	Otter Tail	Redwood	Stevens	

Medical Terminology

All medical terminology referenced in this Certificate of Insurance follows the industry standard definitions of the American Medical Association.

Definitions

Capitalized terms are defined in Section 10 of the Certificate of Insurance.

Conformity with State and Federal Laws

Any provision in this Contract not in conformity with N.D.C.C. chs. 26.1-18.1, 54-52.1, N.D.A.C. chs. 45-06-07, 71-03, and/or any other applicable law or rule in this State, may not be rendered invalid but be must construed and applied as if it were in full compliance with applicable State and Federal laws and rules.

Special Communication Needs

Please call the Plan if you need help understanding written information at (800) 499-3416 *(toll-free)*. We can read forms to you over the phone and we offer free oral translation in any language through our translation services.

Anyone with any disability, who might need some form of accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at 701-328-3900.

Translation Services

The Plan 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) 499-3416 for help and to access translation services.

Spanish (Español): Para obtener asistencia en Español, llame al (800) 892-0675 *(toll-free)*.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 892-0675 *(toll-free)*.
Chinese (中文): 如果需要中文的帮助，请拨打这个号码 (800) 892-0675 *(toll-free)*.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 892-0675 *(toll-free)*.

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

If you are deaf or hearing impaired and need to speak to the Plan, call TTY/TDD: (877) 652-1844 *(toll-free)*. Please contact the Plan toll-free at (800) 499-3416 if you are in need of a large print copy or cassette/CD of this COI or other written materials.

In compliance with the Americans with Disabilities Act, this document can be provided in alternate formats. If you require accommodation or assistance concerning the services or information provided, please contact the NDPERS ADA Coordinator at 701-328-3900.

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Section 1. Schedule of Benefits

General

This section outlines the payment provisions for Covered Services described in Sections 2 and 5; and is subject to the definitions, exclusions, conditions and limitations of this Benefit Plan.

Overview of Cost Sharing Amounts and How They Accumulate

Cost Sharing Amounts include Coinsurance, Copayment, and Deductibles; as well as the Prescription Drug Coinsurance Maximum, Infertility Services Deductible and Out-of-Pocket Maximum Amounts. See *Cost Sharing Amounts – Details & Definitions* later in this Section for more information.

- The Deductible Amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, accumulate jointly up to the PPO Deductible Amount.
- The Out-of-Pocket Maximum Amounts for Covered Services received from a PPO Health Care Provider or on the Basic Plan, accumulate jointly up to the Out-of-Pocket Maximum Amount.
- When the PPO Out-of-Pocket Maximum Amount has been met, all Covered Services received from a PPO Health Care Provider will be paid at 100% of Allowed Charge. Covered Services sought under the Basic Plan will continue to be paid at 75% of the Allowed Charge until the Out-of-Pocket Maximum Amount for Basic Plan services is met.
- Prescription Medication Cost Sharing Amounts do not apply toward the Out-of-Pocket Maximum Amounts.
- Prescription Medication Copayment Amounts do not apply toward the Prescription Drug Coinsurance Maximum Amount.

A Member is responsible for Cost Sharing Amounts. All Members in the family contribute to Deductible and Coinsurance Amounts. However, a Member's contribution cannot be more than the Single Coverage amount. Health Care Providers may bill you directly or request payment of Coinsurance, Copayment and Deductible Amounts at the time services are provided. For the specific benefits and limitations that apply to this Plan, please see Section 2, *Outline of Covered Services*; your Summary of Benefits and Coverage; and Section 5.

If Sanford Health Plan pays amounts to the Health Care Provider that are the Member's responsibility, such as Deductibles, Copayments or Coinsurance Amounts, Sanford Health Plan may collect such amounts directly from the Member. The Member agrees that Sanford Health Plan has the right to collect such amounts from the Member.

Benefit Schedule	Basic Plan	PPO Plan
Under this Benefit Plan the Deductible Amounts are:		
Single Coverage	$400 per Benefit Period	$400 per Benefit Period
Family Coverage	$1,200 per Benefit Period	$1,200 per Benefit Period
Under this Benefit Plan the Coinsurance Maximum Amounts are:		
Single Coverage	$1,250 per Benefit Period	$750 per Benefit Period
Family Coverage	$2,500 per Benefit Period	$1,500 per Benefit Period
Under this Benefit Plan the Out-of-Pocket Maximum Amounts are:		
Single Coverage	$1,650 per Benefit Period	$1,150 per Benefit Period
Family Coverage	$3,700 per Benefit Period	$2,700 per Benefit Period
Under this Benefit Plan the Prescription Drug Coinsurance Maximum Amount is:		
$1,000 per Member per Benefit Period		
Under this Benefit Plan the Lifetime Infertility Services Deductible Amount is:		
$500 per Member		

Selecting a Health Care Provider

The benefit payment available under this Benefit Plan differs depending on the Subscriber's choice of a Health Care Provider. This Benefit Plan recognizes the following categories of Health Care Providers based on the Health Care Provider's relationship with Sanford Health Plan. Providers that are contracted with Sanford Health Plan and participate in the Plan's Network will be paid at either the PPO Plan or Basic Plan level.

Members should refer to the Sanford Health Plan website (www.sanfordhealthplan.com/ndpers) for the Provider Directory, which lists

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Participating Health Care Providers. The Sanford Health Plan website is continuously updated and has the most up-to-date listing of Health Care Providers. Members may also call Member Services at 1-800-499-3416 (toll-free) or TTY/TDD: 1-877-652-1844 (toll-free) to request a provider directory.

How PPO vs. Basic Plan Determines Benefit Payment

PPO Plan

PPO stands for "Preferred Provider Organization" and is a group of Health Care Providers who provide discounted services to the Members of NDPERS. Because PPO Health Care Providers charge Sanford Health Plan less for medical care services provided to the Members of NDPERS, cost savings are passed on to Members by way of reduced Cost Sharing Amounts.

To receive a higher payment level, Covered Services must be received from an NDPERS PPO Health Care Provider. Please see the NDPERS PPO Health Care Provider Listing at www.sanfordhealthplan.com/ndpers.

NOTE: Benefits for Covered Services received by Eligible Dependents, as outlined in Section 3, *Eligibility Requirements for Dependents*, who are residing out of the state of North Dakota, will be paid at the Basic Plan level. If the Subscriber, or the Subscriber's spouse, is required by court order to provide health coverage for that Eligible Dependent, you may be asked to provide a copy of the court order to the Plan.

Basic Plan

If a PPO Health Care Provider is: 1) not available in the Member's area; or 2) if the Member either chooses or is referred to a Health Care Provider not participating in the Preferred Provider Organization (PPO), the Member will receive the Basic Plan benefits.

Other Health Care Providers

Participating Health Care Providers

When Covered Services are received from a Participating Health Care Provider, the Participating Health Care Provider agrees to submit claims to Sanford Health Plan on behalf of the Member. Reimbursement for Covered Services will be made directly to the Participating Health Care Provider according to the terms of this Benefit Plan and the participation agreement between the Health Care Provider and Sanford Health Plan.

When Covered Services are received from a Participating Health Care Provider, a provider discount provision is in effect. This means the Allowance paid by Sanford Health Plan will be considered by the Participating Health Care Provider as payment in full, except for Cost Sharing Amounts, or if applicable, Maximum Benefit Allowances or Lifetime Maximums.

Participating Health Care Providers have also agreed to perform managed benefits requirements on behalf of the Member. If the Health Care Provider is a Participating Health Care Provider, as defined in Section 10, the benefit payment will be as indicated in the Outline of Covered Services and the Member's Summary of Benefits and Coverage (SBC).

Non-participating Health Care Providers

If a Member receives Covered Services from a Non-participating Health Care Provider (health care providers who are not contracted with Sanford Health Plan), the Member will be responsible for notifying Sanford Health Plan of the receipt of services. If Sanford Health Plan needs copies of medical records to process the Member's claim, the Member is responsible for obtaining such records from the Non-participating Health Care Provider.

Non-participating Health Care Providers within the State of North Dakota

If a Member receives Covered Services from a Non-participating Health Care Provider within the state of North Dakota, benefit payments will be based on the Allowance and reduced by an additional 20%. The 20% payment reduction does not apply toward the Out-of-Pocket Maximum Amount. The Allowance will not exceed 80% of the billed charge.

The Member is responsible for the 20% payment reduction and any charges in excess of the Allowance for Covered Services.

Benefit payments will be made directly to the Provider for Covered Services received from a Non-participating Health Care Provider. Sanford Health Plan may designate a Health Care Provider as Non-payable.

Non-participating Health Care Providers outside the State of North Dakota

If a Member receives Covered Services from a Non-participating Health Care Provider outside the state of North Dakota, the Allowance for Covered Services will be an amount within a general range of payments made and judged to be reasonable by Sanford Health Plan.

The Member is responsible for any charges in excess of the Allowance for Covered Services.

If a Member receives Covered Services from a Health Care Provider in a county contiguous to North Dakota, the benefit payment will be provided on the same basis as a Health Care Provider located in the state of North Dakota. If the Health Care Provider is a Participating Health Care Provider, the benefit payment will be as indicated in the Outline of Covered Services and SBC. If the Health Care Provider is not a Participating Health Care Provider, benefits will be available at the same level as Non-participating Health Care Providers within the state of North Dakota. Sanford Health Plan may designate a Health Care Provider as Non-payable.

Non-participating Providers outside the Sanford Health Plan Service Area

When Covered Services are provided outside of Sanford Health Plan's Service Area by health care providers who have not entered into a "participating agreement" with Sanford Health Plan (non-participating health care providers), the amount the Member pays for such services will generally be based on either Sanford Health Plan's non-participating health care provider local payment or the pricing arrangements required by applicable state law. In these situations, the Member may be liable for the difference between the amount that the non-participating health care provider bills and the payment Sanford Health Plan will make for the Covered Services as set forth in this paragraph.

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In certain situations, Sanford Health Plan may use other payment bases, such as the payment Sanford Health Plan would make if the Covered Services had been obtained within the Sanford Health Plan Service Area, or a special negotiated payment, as permitted, to determine the amount Sanford Health Plan will pay for Covered Services provided by non-participating health care providers. In these situations, a Member may be liable for the difference between the amount that the non-participating health care provider bills and the payment Sanford Health Plan will make for the Covered Services as set forth in this paragraph.

Health Care Providers outside the United States

The benefits available under this Benefit Plan are also available to Members traveling or living outside of the United States. The same Preauthorization/Prior Approval requirements will apply. If the Health Care Provider is a Participating Provider, the Participating Health Care Provider will submit claims for reimbursement on behalf of the Member. Reimbursement for Covered Services will be made directly to the Participating Health Care Provider. If the Health Care Provider is not a Participating Provider, the Member will be responsible for payment of services and submitting a claim for reimbursement to Sanford Health Plan. Sanford Health Plan will provide translation and currency conversion services for the Member's claims outside of the United States.

Sanford Health Plan will reimburse Prescription Medications purchased outside the United States by Members who live outside the United States where no suitable alternative exists. Reimbursement will also be made in instances where Members are traveling and new drug therapy is initiated for acute conditions, or where emergency replacement of medications originally prescribed and purchased in the United States is necessary. The reimbursable supply of medications in travel situations will be limited to an amount necessary to assure continuation of therapy during the travel period and for a reasonable period thereafter.

Non-payable Health Care Providers

If Sanford Health Plan designates a Health Care Provider as *Non-payable*, no benefits will be available for Covered Services prescribed by, performed by or under the direct supervision of the *Non-payable Health Care Provider*. Notice of designation as a Non-payable Health Care Provider will be provided to Members at least 30 days prior to the effective date of designation as a Non-payable Health Care Provider. As of the date of termination, all charges incurred by a Member for services received from the Non-payable Health Care Provider will be the Subscriber's responsibility.

Medicare Private Contracts

A Health Care Provider may ask a Member who is eligible for Medicare to enter into a Medicare private contract where the Member and the Health Care Provider agree that the Member is to be provided with services outside of the Medicare program. This Medicare private contract must be entered into between the Member and the Health Care Provider prior to the receipt of any services and indicate that neither the Member nor the Health Care Provider is permitted to file a request for reimbursement with Medicare for any of the services provided by the Health Care Provider and that the Health Care Provider can charge any amount agreed to by the Member for services instead of the Medicare limiting charge.

Under a Medicare private contract, the Health Care Provider can set any price for services but Medicare will not pay anything. If the Member enters into a Medicare private contract, Medicare will not pay any portion of the services and Sanford Health Plan will limit its payment to the amount Sanford Health Plan would have paid as though Medicare was paying for such Covered Services. If a Member enters into a Medicare private contract, the Member is responsible for paying the difference between the amount billed by the Health Care Provider for Covered Services and the amount paid by Sanford Health Plan.

Cost Sharing Amounts – Details & Definitions

A Cost Sharing Amount is the dollar amount a Member is responsible for paying when Covered Services are received from a Health Care Provider. Cost Sharing Amounts include Coinsurance, Copayment and Deductible Amounts. Applicable Cost Sharing Amounts are identified in Section 2 and the Member's Summary of Benefits and Coverage. See the schedule above in *Overview of Cost Sharing Amounts and how they accumulate* for the specific Cost Sharing Amounts that apply to this Benefit Plan.

Coinsurance

Sanford Health Plan shall calculate Coinsurance Amounts on behalf of Members obtaining Covered Services within the Sanford Health Plan contracted provider network on the lesser of (1) billed charges or (2) provider negotiated payment rates (Allowed Charge).

If Covered Services are obtained by a Member out of the Sanford Health Plan contracted provider network, the coinsurance calculation may be based on the Health Care Provider's billed charges. This may result in a significantly higher Coinsurance Amount for certain services a Member incurs out of the Sanford Health Plan contracted provider network. It is not possible to provide specific information for each Health Care Provider outside of Sanford Health Plan's Service Area because of the many different arrangements between Health Care Providers. However, if a Member contacts Sanford Health Plan prior to receiving services from a Health Care Provider outside of Sanford Health Plan's Service Area, Sanford Health Plan may be able to provide information regarding specific Health Care Providers.

Coinsurance Maximum Amounts

The total Coinsurance Amount that is a Member's responsibility during a Benefit Period. The Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period.

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Deductibles

The Deductible Amount renews on January 1 of each consecutive Benefit Period. Copayment Amounts do not apply toward the Deductible Amount.

NOTE: The Deductible Amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, cross accumulate jointly up to the PPO Deductible Amount.

Out-of-Pocket Maximum Amounts

When the Out-of-Pocket Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Covered Services, less Copayment Amounts incurred during the remainder of the Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1st of each consecutive Benefit Period. Prescription Medication Cost Sharing Amounts do not apply toward the Out-of-Pocket Maximum Amount.

NOTE: The Out-of-Pocket Maximum Amounts for Covered Services received from a PPO Health Care Provider, or on a Basic Plan basis, cross accumulate jointly up to the PPO Out-of-Pocket Maximum Amount.

NOTE: When the PPO Out-of-Pocket Maximum Amount has been met, all Covered Services received from a PPO Health Care Provider will be paid at 100% of Allowed Charge. **Covered Services sought on a Basic Plan basis will continue to be paid at 75% of the Allowed Charge until the Out-of-Pocket Maximum Amount for Basic Plan services is met.**

Prescription Drug Coinsurance Maximum Amount

When the Prescription Drug Coinsurance Maximum Amount that is a Member's responsibility during a Benefit Period is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications, less Copayment Amounts incurred during the remainder of the Benefit Period. This Prescription Drug Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period. **Copayment Amounts do not apply toward this Coinsurance Maximum Amount**.

Infertility Services Coinsurance/Deductible

Neither the Infertility Services Lifetime Deductible Amount nor any Member-paid coinsurance for infertility services applies toward the annual Out-of-Pocket Maximum Amounts. Infertility services are limited per Member to a lifetime benefit maximum of $20,000.

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Section 2. Outline of Covered Services

Covered Services	PROVIDER OF SERVICE Basic Plan *After Deductible Amount*	PPO Plan *After Deductible Amount*
Inpatient Hospital and Medical Services		
• **Inpatient Hospital Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Inpatient Medical Care Visits**	75% of Allowed Charge.	80% of Allowed Charge.
• **Ancillary Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Inpatient Consultations**	75% of Allowed Charge.	80% of Allowed Charge.
• **Concurrent Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Initial Newborn Care**	75% of Allowed Charge. *Deductible Amount is waived.*	80% of Allowed Charge. *Deductible Amount is waived.*
Inpatient and Outpatient Surgical Services		
• **Professional Health Care Provider Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Assistant Surgeon Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Ambulatory Surgical Facility Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Hospital Ancillary Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Anesthesia Services**	75% of Allowed Charge.	80% of Allowed Charge.
Transplant Services		
• **Inpatient and Outpatient Hospital and Medical Services**	75% of Allowed Charge. *Preauthorization/Prior Approval required.*	80% of Allowed Charge. *Preauthorization/Prior Approval required.*
• **Transportation Services**	75% of Allowed Charge. *Benefits are subject to a Maximum Benefit Allowance of $1,000 per transplant procedure.*	80% of Allowed Charge.
Dental Services		
• **Temporomandibular (TMJ) or Craniomandibular (CMJ) Joint Treatment**	75% of Allowed Charge. *Benefits are subject to a Maximum Benefit Allowance of 1 splint per Member per Benefit Period.*	80% of Allowed Charge.
• **Dental Services Related to Accidental Injury**	75% of Allowed Charge.	80% of Allowed Charge.
• **Dental Anesthesia and Hospitalization**	75% of Allowed Charge. *Preauthorization/Prior Approval is required for all Members age 9 and older.*	80% of Allowed Charge. *Preauthorization/Prior Approval is required for all Members age 9 and older.*
Outpatient Hospital and Medical Services		
• **Home and Office Visits**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
• **Diagnostic Services**	75% of Allowed Charge.	80% of Allowed Charge.

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Covered Services	PROVIDER OF SERVICE Basic Plan *After Deductible Amount*	PPO Plan *After Deductible Amount*
• **Emergency Services**	$50 Copayment Amount, then 80% of Allowed Charge for emergency room facility fee billed by a Hospital. *The Copayment Amount for the emergency room facility fee is waived when a Member is admitted directly as an Inpatient to a Hospital.*	$50 Copayment Amount, then 80% of Allowed Charge for emergency room facility fee billed by a Hospital.
	80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider. *Deductible Amount is waived.*	80% of Allowed Charge for office or emergency room visit billed by a Professional Health Care Provider. *Deductible Amount is waived.*
	80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.	80% of Allowed Charge for all Ancillary Services received in an emergency room or Professional Health Care Provider's office.
• **Ambulance Services**	80% of Allowed Charge.	80% of Allowed Charge.
• **Radiation Therapy and Chemotherapy**	75% of Allowed Charge.	80% of Allowed Charge.
• **Dialysis Treatment**	75% of Allowed Charge.	80% of Allowed Charge.
• **Home Infusion Therapy Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Visual Training for Members under age 10**	75% of Allowed Charge. *Benefits are subject to an Annual Maximum of 16 visits per Member.*	80% of Allowed Charge.
• **Allergy Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Phenylketonuria (PKU)** - *Foods and food products for the dietary treatment of Members born after 12/31/62 with maple syrup urine disease or phenylketonuria (PKU)*	75% of Allowed Charge.	80% of Allowed Charge.

Wellness Services

The Plan will pay up to a Maximum Benefit Allowance of $200 per Member per Benefit Period for any non-routine screening services not listed below or not recommended with a rating of "A" or "B" by the United States Preventive Services Task Force. Such non-routine screening services will be subject to Copayment, Deductible and Coinsurance amounts after the $200 Benefit Allowance has been met.

• **Well Child Care to the Member's 6th birthday**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available as follows:* • *7 visits for Members from birth through 12 months;* • *3 visits for Members from 13 months through 24 months; and* • *1 visit per Benefit Period for Members 25 months through 72 months.*	$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Well Child Care Immunizations to the Member's 6th Birthday**	100% of Allowed Charge. *Deductible Amount is waived.* *Covered immunizations are those that have been published as policy by the Centers for Disease Control, including DPT (Diphtheria-Pertussis-Tetanus); MMR (Measles-Mumps-Rubella); Hemophilus; Influenza B; Hepatitis; Polio; Varicella (Chicken Pox); Pneumococcal Disease; and Influenza Virus.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Preventive Screening Services for Members age 6 and older**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Benefits include:* • *One routine physical examination per Member per Benefit Period.* • *Routine diagnostic screenings.* • *Routine screening procedures for cancer.* *A Health Care Provider will counsel Members as to how often preventive services are need based on the age, gender and medical status of the Member.*	$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*

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Covered Services	PROVIDER OF SERVICE Basic Plan *After Deductible Amount*	PPO Plan *After Deductible Amount*
• **Mammography Screening Services**	100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available as follows:* • *One service for Members between the ages of 35 and 40* • *One service per year for Members age 40 and older.* *Additional benefits will be available for mammography services when Medically appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 5(a).*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Routine Pap Smear**	100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are subject to a Maximum Benefit Allowance of 1 Pap smear per Benefit Period.*	100% of Allowed Charge. *Deductible Amount is waived.*
Related Office Visit	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Additional benefits will be available for Pap smears when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 5(a).*	$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Prostate Cancer Screening**	75% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available for an annual digital rectal examination and an annual prostate-specific antigen test for an asymptomatic male age 50 and older and a male age 40 with a family history of prostate cancer.*	80% of Allowed Charge. *Deductible Amount is waived.*
Related Office Visit	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Additional benefits will be available for prostate cancer screening when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 5(a).*	$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Fecal Occult Blood Testing for Colorectal Cancer Screening**	100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available for Members age 50 and older, subject to a Maximum Benefit Allowance of 1 test per Benefit Period.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Immunizations other than Well Child Care**	100% of Allowed Charge. *Deductible Amount is waived.* *Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including Tetanus, Influenza Virus, Pneumococcal Pneumonia, MMR (Measles-Mumps-Rubella), Varicella (Chicken Pox), Shingles (Zoster) Vaccine, Meningococcal Disease and Human Papillomavirus (HPV). Certain age restrictions may apply.*	100% of Allowed Charge. *Deductible Amount is waived.*
• **Outpatient Nutritional Care Services**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available to the Maximum Benefit Allowance for the following diagnosed medical conditions:* • *Hyperlipidemia – Two (2) Office Visits per Member per Benefit Period.* • *Gestational Diabetes – Two (2) Office Visits per Member per Benefit Period.* • *Chronic Renal Failure – Four (4) Office Visits per Member per Benefit Period.* • *Diabetes Mellitus – Four (4) Office Visits per Member per Benefit Period.* • *Anorexia Nervosa – Four (4) Office Visits per Member per Benefit Period.* • *Bulimia – Four (4) Office Visits per Member per Benefit Period.* • *PKU – Four (4) Office Visits per Member per Benefit Period.* • *Obesity – One (1) Office Visit per Member per Benefit Period.*	$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Diabetes Education Services**	75% of Allowed Charge. *Deductible Amount is waived.*	80% of Allowed Charge. *Deductible Amount is waived.*

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Covered Services	PROVIDER OF SERVICE Basic Plan *After Deductible Amount*	PPO Plan *After Deductible Amount*
• **Dilated Eye Examination** *(for diabetes related diagnosis)*	$30 Copayment Amount, then 75% of Allowed Charge. *Deductible Amount is waived.* *Benefits are subject to a Maximum Benefit Allowance of 1 examination per Member per Benefit Period.*	$25 Copayment Amount, then 80% of Allowed Charge. *Deductible Amount is waived.*
Outpatient Therapy Services		
• **Physical Therapy**	$25 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.* *Benefits are subject to the medical guidelines established by Sanford Health Plan.*	$20 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
• **Occupational Therapy**	$25 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available for 90 consecutive calendar days, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.*	$20 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
• **Speech Therapy**	$25 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.* *Benefits are available for 90 consecutive calendar days, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Appropriate and Necessary.*	$20 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
• **Respiratory Therapy Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Cardiac Rehabilitation Services**	75% of Allowed Charge. *Deductible Amount is waived.* *Benefits are subject to a Maximum Benefit Allowance of 12 visits per Member per episode for the following diagnosed medical conditions:* • *Myocardial Infarction* • *Coronary Artery Bypass Surgery* • *Coronary Angioplasty and Stenting* • *Heart Valve Surgery* • *Heart Transplant Surgery* *Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital.*	80% of Allowed Charge. *Deductible Amount is waived.*
• **Pulmonary Rehabilitation Services**	75% of Allowed Charge. *Deductible Amount is waived.*	80% of Allowed Charge. *Deductible Amount is waived.*
Chiropractic Services	**Only the Office Visit Copayment Amount will apply if both an Office Visit and Therapy/Manipulation are billed on the same day by the same Health Care Provider.**	
• **Home and Office Visits**	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*
• **Therapy and Manipulations**	$25 Copayment Amount per visit, then 75% of Allowed Charge. *Deductible Amount is waived.*	$20 Copayment Amount per visit, then 80% of Allowed Charge. *Deductible Amount is waived.*
• **Diagnostic Services**	75% of Allowed Charge.	80% of Allowed Charge.
Maternity Services	**The Deductible Amount is waived for delivery services received from a PPO Health Care Provider when the Member is enrolled in the Healthy Pregnancy Program.**	
• **Inpatient Hospital and Medical Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Prenatal and Postnatal Care**	75% of Allowed Charge. *Deductible Amount is waived.*	80% of Allowed Charge. *Deductible Amount is waived.*

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Covered Services	PROVIDER OF SERVICE Basic Plan *After Deductible Amount*	PPO Plan *After Deductible Amount*
• **One (1) Prenatal Nutritional Counseling visit per pregnancy**	100% of Allowed Charge. *Deductible Amount is waived.*	100% of Allowed Charge. *Deductible Amount is waived.*
Infertility Services		
• **Diagnostics, Treatment, Office Visits, and other Services**	80% of Allowed Charge. *Benefits are subject to a $500 Lifetime Infertility Services Deductible Amount and a $20,000 Lifetime Benefit Maximum Amount per Member. The Infertility Services Deductible Amount and any Member-paid coinsurance for infertility services do not apply toward the Out-of-Pocket Maximum Amount. Prior Approval is required for assisted reproductive technology, including GIFT, ZIFT, ICSI and IVF.*	80% of Allowed Charge.
Mental Health and Substance Use Disorder Treatment Services		
• **Mental Health Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	75% of Allowed Charge. *Preauthorization/Prior Approval is required.*	80% of Allowed Charge. *Preauthorization/Prior Approval is required.*
Outpatient	*For all Outpatient Services, 100% of the Allowed Charge (includes Copayment and Deductible/Coinsurance) is waived for the initial 5 hours, per Member per Benefit Period.*	
Office Visits	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
All Other Services, including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and subject to Deductible Amounts.*	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to Deductible Amounts.*
• **Substance Use Disorder Treatment Services**		
Inpatient		
Includes Acute Inpatient Admissions and Residential Treatment	75% of Allowed Charge. *Preauthorization/Prior Approval is required.*	80% of Allowed Charge. *Preauthorization/Prior Approval is required.*
Outpatient	*For all Outpatient Services, 100% of Allowed Charge (includes Copayment and Deductible/Coinsurance) is waived for the initial 5 visits, per Member per Benefit Period.*	
Office Visits	$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived.*	$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. *Deductible Amount is waived*
All Other Services, including:		
Intensive Outpatient	80% of Allowed Charge.	80% of Allowed Charge.
Partial Hospitalization	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*	80% of Allowed Charge. *Covered Services received during the remainder of the Benefit Period are payable at 80% of Allowed Charge and are subject to any Deductible Amount.*

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Covered Services	PROVIDER OF SERVICE Basic Plan *After Deductible Amount*	PPO Plan *After Deductible Amount*
Other Services Not Previously Listed Above		
• **Skilled Nursing Facility Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Home Health Care Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Hospice Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Private Duty Nursing Services**	75% of Allowed Charge.	80% of Allowed Charge.
• **Medical Supplies and Equipment** • Home Medical Equipment • Prosthetic Appliances and Limbs • Orthotic Devices • Supplies for Administration of Prescription Medications other than the diabetes supplies specified in Section 5(e) • Oxygen Equipment and Supplies • Ostomy Supplies	75% of Allowed Charge.	80% of Allowed Charge.
• Hearing aids for Members under age 18	*Subject to a Benefit Allowance of 1 hearing aid per ear, per Member, every 3 years.*	
• **Eyeglasses or Contact Lenses** *(following a covered cataract surgery)*	75% of Allowed Charge. *Benefits are subject to a Maximum Allowance of 1 pair of eyeglasses or contact lenses per Member when purchased within 6 months following the surgery.*	80% of Allowed Charge.
Prescription Drug and Diabetes Supplies Benefits		
• **Retail and Mail Order**		
Formulary Medication		
➢ Generic	$5 Copayment Amount, then 85% of Allowed Charge. Benefits are subject to the Prescription Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*	
➢ Brand Name	$20 Copayment Amount, then 75% of Allowed Charge. Benefits are subject to the Prescription Drug Coinsurance Maximum Amount and the Copayment Amount application listed below. *Deductible Amount is waived.*	
Non-Formulary Medication		
➢ Generic and Brand Name	$25 Copayment Amount, then 50% of Allowed Charge. Benefits are subject to the Copayment Amount application listed below. *Deductible Amount is waived.*	

Under this Benefit Plan the Prescription Drug Coinsurance Maximum Amount is:

$1,000 per Member per Benefit Period

Copayment Amount Application

- One Copayment Amount per Prescription Order or refill for a 1 – 34-day supply.
- Two Copayment Amounts per Prescription Order or refill for a 35 – 100-day supply.

Copayment Amounts do not apply to the following nonprescription diabetes supplies: syringes, lancets, blood glucose test strips, urine test products and control solutions.

If a Generic Prescription Medication is the therapeutic equivalent for a Brand Name Prescription Medication, and is authorized by a Member's Professional Health Care Provider, benefits will be based on the Allowance for the Generic equivalent. If the Member does not accept the Generic equivalent, the Member is responsible for the cost difference between the Generic and the Brand Name Prescription Medication, and applicable Cost Sharing Amounts. For details, see Section 5(e).

Prescription Medication Cost Sharing Amounts do not apply toward the Member's Out-of-Pocket Maximum Amounts. Prescription Medications and nonprescription diabetes supplies are subject to a dispensing limit of a 100-day supply.

Cost Sharing Amounts are waived for prenatal vitamins when the Member is enrolled in the Healthy Pregnancy Program. For details, see Sections 5(a) and 5(e).

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Section 3. Enrollment

Eligibility and When to Enroll

As provided in N.D.C.C. §54-52.1-01(4), individuals eligible to receive benefits are every permanent employee who is employed by a governmental unit, as that term is defined in N.D.C.C. §54-52-01, whose services are not limited in duration, who is filling an approved and regularly funded position in a governmental unit, and who is employed at least seventeen and one-half hours per week and at least five months each year or for those first employed after August 1,2003, is employed at least twenty hours per week and at least twenty weeks each year of employment. An eligible employee includes members of the Legislative Assembly, judges of the Supreme Court, paid members of state or political subdivision boards, commissions, or associations, full-time employees of political subdivisions, elective state officers as defined by N.D.C.C. §54-06-01(2), and disabled permanent employees who are receiving compensation from the North Dakota workforce safety and insurance fund.

A temporary employee employed before August 1, 2007, may elect to participate in the uniform group insurance program by completing the necessary enrollment forms and qualifying under the medical underwriting requirements of the program if such election is made before January 1, 2015, and if the temporary employee is participating in the uniform group insurance program on January 1, 2015. In order for a temporary employee employed after July 31, 2007, to qualify to participate in the uniform group insurance program, the employee must be employed at least twenty hours per week; must be employed at least twenty weeks each year of employment; must make the election to participate before January 1, 2015; and must be participating in the uniform group insurance program as of January 1, 2015. To be eligible to participate in the uniform group insurance program, a temporary employee first employed after December 31, 2014, or any temporary employee not participating in the uniform group insurance program as of January 1, 2015, must meet the definition of a full-time employee under §4980H(c)(4) of the Internal Revenue Code [26 U.S.C. 4980H(c)(4)].

An eligible employee is entitled to coverage the first of the month following the month of employment, provided the employee submits an application for coverage within the first 31 days of employment or eligibility for a special enrollment period as set forth in N.D.A.C. §71-03-03. Each eligible employee may elect to enroll his/her Eligible Dependents.

Eligible employees also include non-Medicare eligible retired and terminated employees, and their Eligible Dependents, who remain eligible to participate in the uniform group insurance program pursuant to applicable state law, as provided in N.D.C.C. §54-52.1-03 and federal regulations. For a comprehensive description of eligibility, refer to the NDPERS web site at www.nd.gov/ndpers.

Eligibility to receive benefits under the Benefit Plan is initially determined by the Plan Administrator. When an eligible employee meets the criteria for eligibility, a membership application must be completed. NDPERS has the ultimate decision making authority regarding eligibility to receive benefits.

A "Late Enrollee" is an Eligible Group Member or Eligible Dependent who declines coverage when he or she is initially eligible to enroll and later requests to enroll for coverage. A Late Enrollee can only enroll during the next scheduled Annual Enrollment Period. A Member is not a "Late Enrollee" if any "special enrollment right(s)" apply, as described later in this section.

How to Enroll

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

The Group Member must:

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

The Group must:

1. Provide all information needed by the Plan to determine eligibility; and
2. Agree to pay the required premium payments on behalf of the Group Member.

When Coverage Begins

Coverage generally becomes effective on the first day of the month that follows the date of hire, as designated by NDPERS.

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

Eligibility Requirements for Dependents

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

Spouse - The Subscriber's spouse, under a legally existing marriage between persons of the opposite sex, is always eligible for coverage, subject to the eligibility requirements as designated by NDPERS.

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

1. Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child; and
2. Be one of the following:
   a. under age twenty-six (26); or
   b. incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Policyholder/Subscriber for support and maintenance If the Plan so requests, the Subscriber must provide proof of the child's disability within *thirty-one (31)* days of the Plan's request; or

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c. the Subscriber's grandchild(ren) or those of the Subscriber's living, covered Spouse, who legally reside with the Policyholder/Subscriber and (1) the parent of the grandchild(ren) is an Covered Dependent also covered by this Plan; and (2) both the Dependent and child of such Dependent (grandchild) are chiefly dependent upon the Policyholder/Subscriber for support.

Dependent coverage does not include the spouse of an adult Dependent child. Coverage will continue to the end of the month in which the adult Dependent child reaches the limiting age. Coverage does not include the adult Dependent child's spouse or child of such Dependent (grandchild) unless that grandchild meets other coverage criteria established under state law. The adult Dependent's marital status, financial dependency, residency, student status or employment status will not be considered in determining eligibility for initial or continued coverage.

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

Noncustodial Subscribers

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

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

Status of Member Eligibility

The Plan Administrator agrees to furnish Sanford Health Plan with any information required by Sanford Health Plan for the purpose of enrollment. Any changes affecting a Member's eligibility for coverage must be provided to Sanford Health Plan by the Plan Administrator and/or the Member immediately, but in any event, the Plan Administrator and/or the Member shall notify Sanford Health Plan within 31 days of the change.

Statements made on membership applications are deemed representations and not warranties. No statements made on the membership application may be used in any contest unless a copy has been furnished to that person, or in the event of the death or incapacity of that person, to the individual's beneficiary or personal representative. The Subscriber is provided a copy of the membership application at the time of completion.

A Member making a statement (including the omission of information) on the membership application 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 this Benefit Plan by Sanford Health 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.

Physical Examinations

Sanford Health Plan at its own expense may require a physical examination of the Member as often as 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.

Qualified Medical Child Support Order (QMCSO) Provision

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

When the Plan is in receipt of a medical child support order, the Plan will notify the Member and each child named in the order, that the Plan is in receipt of a QMCSO which contains the following required information:

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

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

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

1. The court or administrative order is no longer in effect;
2. The Dependent Child is or will be enrolled in comparable health coverage through an insurer which will take effect not later than the effective date of the termination; or
3. The Group has eliminated family coverage for all of its Members.

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Michelle's Law

Federal law requires that we provide the following notice regarding Michelle's Law [Public Law 110-381]. Please note that changes in federal law may eliminate certain elements of Michelle's Law, and the Plan intends to provide continuing coverage of Eligible Dependents up to age twenty-six (26), irrespective of their student status, for Plan Years beginning on or after September 23, 2010.

A Dependent Child under twenty-five (25) years old and enrolled in and attending an accredited college, university, or trade or secondary school at least five (5) months each year will remain covered if the Dependent takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

1. Be medically necessary;
2. Commence while the child is suffering from a serious illness or injury; and
3. Cause the child to lose coverage under the plan.

Students are only eligible as long as they were covered by their parent's health insurance policy prior to diagnosis. Coverage will continue until the earlier of one year from the first day of the leave of absence or the date on which coverage would otherwise terminate because the child no longer meets the requirements to be an Eligible Dependent (e.g., reaching the plan's limiting age).

You must provide a written and signed certification from the Dependent Child's treating Practitioner and/or Provider stating that the Dependent Child is suffering from a serious illness or injury and that the leave of absence is medically necessary and the effective date of the leave.

When and How to Enroll Dependents

When to Enroll Dependents

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

How to Enroll Dependents

The Group Member must:

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

When Dependent Coverage Begins

1. **General.** If a Dependent is enrolled at the same time the Subscriber enrolls for coverage, the Dependent's effective date of coverage will be the same as the Subscriber's effective date as described in "*When Coverage Begins*" above.
2. **Delayed Effective Date of Dependent Coverage.** Except for newborns (see item 3 below), if, on the date Dependent coverage becomes effective, the Dependent is Hospitalized and covered under an extension of health benefits from a previous Group health plan or other coverage arrangement, coverage under this Contract shall not begin until the extension under the prior coverage ends.
3. **Coverage from Birth.** If a Subscriber has a child through birth, the child will become a covered Dependent from the date of birth, provided that coverage is applied for the child within thirty-one (31) days from the newborn's date of birth, if the Subscriber had Single Coverage under the Plan. Subscribers with Family Coverage are encouraged to notify the plan in advance when a pregnancy and expected due date is known. Newborn children will be added to the policy automatically if the Subscriber is enrolled in Family Coverage and the Plan is notified of the pregnancy.

   An Eligible Group Member, and any other Dependents, eligible to be enrolled in the Plan, but who failed to enroll during a previous enrollment period, shall be covered under this Contract from the date of the newborn child's birth, provided that coverage is applied for through NDPERS within thirty-one (31) days. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the employee's Eligible Dependent is enrolled.

   Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for coverage under the Plan, provided coverage is applied through NDPERS for the Spouse and, if applicable, the Group Member, within thirty-one (31) days of the newborn child's birth.
4. **Adoption or Children Placed for Adoption.** If a Subscriber adopts a child or has a child placed with him or her as a Dependent, that child will become covered as an Eligible Dependent as of the date specified within a court order or other legal adoption papers, if the Subscriber submits application for coverage to NDPERS within thirty-one (31) days of the date specified court order or other legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage.

   An Eligible Group Member, and any other Dependents, eligible to be enrolled in the Plan, who failed to enroll during a previous enrollment period, shall be covered as of the date specified within a court order or other legal adoption papers, if the Eligible Group Member, and any other Eligible Dependents, submits an application for coverage to NDPERS within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the employee's Eligible Dependent is enrolled.

   Dependent coverage is available for the Spouse, if the Spouse is otherwise eligible for coverage under the Plan, provided that an application for coverage is submitted to NDPERS for the Spouse and, if applicable, the Group Member, within thirty-one (31) days of the date specified within the court order or in the legal adoption papers granting an adoption, placement for adoption, legal guardianship, or order to provide health coverage.

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

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5. **New Spouses and Dependent Children.** If a Subscriber gets married, his or her Spouse, and any of the Spouse's Dependents who become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for the Spouse and/or the Dependent within thirty-one (31) days of the date of marriage.

   If an Eligible Group Member, who is an Employee eligible to enroll in the Plan, but who did not do so during a previous enrollment period, gets married, the employee becomes an eligible Subscriber under the following conditions. The Subscriber, his or her Spouse, and any Dependents who become Eligible Dependents of the Subscriber as a result of the marriage, will become covered as a Member from the first day of the calendar month beginning after the date of marriage, provided that coverage is applied for within thirty-one (31) days of the date of marriage. Pursuant to N.D.A.C. §71-03-03-01, an employee who previously waived coverage must enroll for coverage at the same time that the employee's Eligible Dependent is enrolled.

Special Enrollment Rights

A. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any mailing address change within 31 days of the change.

B. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) of any change in marital status within 31 days of the change.

1. If the Subscriber marries, Eligible Dependents may be added as a Member if a membership application is submitted within 31 days of the date of marriage. If the membership application is not submitted within the 31-day period, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

   If the membership application is submitted within 31 days of the date of marriage, the effective date of coverage for the Eligible Dependent will be the first of the month immediately following the date of marriage. If the membership application is not submitted within 31 days of the date of marriage and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
2. If a Member becomes otherwise ineligible for group membership under this Benefit Plan due to legal separation, divorce, annulment, or death, coverage for the Subscriber's Spouse and/or Dependents under Family Coverage will cease, effective the first of the month immediately following timely notice of the event causing ineligibility.

   If living in the Sanford Health Plan Service Area (see *Service Area* in Introduction Section), a Member has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit www.sanfordhealthplan.com or call Member Services toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (toll-free).

   There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit www.healthcare.gov or call 1-800-318-2596 | TTY/TDD: 1-855-889-4325.

C. The Subscriber is responsible for notifying the Plan Administrator (NDPERS) and Sanford Health Plan of any change in family status within 31 days of the change.

The effective date of coverage for dependents added to this Benefit Plan within the designated time period will be the date of birth, physical placement, or the first of the month immediately following the date established by court order. If a membership application is not submitted within the designated time period and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

The following provisions will apply:

1. At the time of birth, natural children will automatically be added to the Subscriber's Benefit Plan if Family Coverage is in force. If the Subscriber is enrolled under another Class of Coverage, the Subscriber must submit a membership application for the newborn child within 31 days of the date of birth. If the membership application is not submitted within the designated time period and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
2. Adopted children may be added to this Benefit Plan if a membership application, accompanied by a copy of the placement agreement or court order, is submitted to Sanford Health Plan within 31 days of physical placement of the child. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
3. Children for whom the Subscriber or the Subscriber's living, covered spouse have been appointed legal guardian may be added to this Benefit Plan by submitting a membership application within 31 days of the date legal guardianship is established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
4. Children for whom the Subscriber or the Subscriber's living, covered spouse are required by court order to provide health benefits may be added to this Benefit Plan by submitting a membership application within 31 days of the date established by court order. If the membership application is not received in accordance with this provision and the child is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.
5. If any of the Subscriber's children, who are beyond the age of 26 and incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Policyholder/Subscriber for support and maintenance, coverage will remain in effect as long as the disabled child remains dependent upon the Policyholder/Subscriber or the Subscriber's spouse for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within *thirty-one (31)* days of the Plan's request.
6. If a child is no longer an Eligible Dependent under this Benefit Plan, and the child is living in the Sanford Health Plan Service Area

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(see *Service Area* in the above Introduction Section), the Dependent has the option to continue coverage through one of Sanford Health Plan's individual plans. For more information on options available through Sanford Health Plan, visit www.sanfordhealthplan.com or call Member Services toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (toll-free). There may also be other coverage options through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as another employer's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more about offerings on the Marketplace, and options outside the Sanford Health Plan Service Area, visit www.healthcare.gov or call 1-800-318-2596 | TTY/TDD: 1-855-889-4325.

7. At the time of birth or adoption, Eligible Dependents may be added to this Benefit Plan if a membership application is submitted to NDPERS within 31 days of birth or physical placement of the adopted child. If the membership application is not received in accordance with this provision, and the Eligible Dependent is a Late Enrollee, the effective date of coverage will be the Group's anniversary date.

D. Employees and/or dependents who previously declined coverage under this Benefit Plan will be able to enroll under this Benefit Plan if each of the following conditions are met:

1. During the initial enrollment period the employee or dependent states, in writing, that coverage under a group health plan or health insurance coverage was the reason for declining enrollment at such time.
2. The employee's or dependent's coverage under a group health plan or other health insurance coverage:
   a. was either terminated as a result of loss of eligibility (Including loss as a result of legal separation, divorce, death, termination of employment or reduction of hours, loss as a result of having a subsequent opportunity for late enrollment [including the Annual Enrollment Period] or special enrollment under the Benefit Plan but again choosing not to enroll, or employer contributions toward such coverage were terminated; or
   b. was under COBRA and the coverage was exhausted.
3. The employee requests such enrollment within 31 days after the exhaustion or termination of coverage.

The effective date of coverage for an employee and/or dependent that previously declined coverage under this Benefit Plan, and is enrolling pursuant to this provision, will be the first of the month following the exhaustion or termination of the employee's and/or dependent's previous coverage. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

If the membership application is not received in accordance with this provision and the employee or dependent is a Late Enrollee, the Late Enrollee's effective date of coverage will be the Group's anniversary date.

E. Employees and/or dependents will be able to enroll under this Benefit Plan if either of the following conditions is met:

1. The employee or dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of the Social Security Act and the employee's or dependent's coverage under such a plan is terminated as a result of loss of eligibility. The employee must request enrollment within 60 days of the date of termination of coverage; or
2. The employee or dependent becomes eligible for premium assistance under a Medicaid plan under Title XIX of the Social Security Act or under a state child health plan under Title XXI of the Social Security Act. The employee must request enrollment within 60 days of the date the employee or dependent is determined to be eligible for premium assistance.

   The effective date of coverage under this Benefit Plan for an employee and/or dependent enrolling pursuant to this provision will be the first day immediately following the termination of coverage or eligibility for premium assistance. The employee and/or dependent shall be responsible for any and all premium payments from the effective date of coverage under this provision through the date the employee and/or dependent requests enrollment under the terms of this Benefit Plan.

NOTE: The following do not qualify for a special enrollment period: 1) Loss of Minimum Essential Coverage due to failure to make premium payment and/or allowable rescissions of coverage; 2) Voluntarily terminating/dropping COBRA coverage before it runs out outside Annual Enrollment. COBRA coverage must be exhausted (usually 18 or 36 months) or another qualifying life event must occur before eligible for special enrollment.

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 terminated from Medicaid or CHIP coverage or being 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 1-866-444-3272 (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 **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply.

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Section 4. How You Get Care

Identification cards

The Plan will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Provider, a health care Facility, or fill a prescription at a Plan pharmacy. If you fail to show your ID card at the time you receive health care services or prescription medications, you may be responsible for payment of the claim after the 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 *thirty (30)* days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-499-3416 or write to us at Sanford Health Plan, ATTN: NDPERS, PO Box 91110 Sioux Falls, SD 57109-1110. You may also request replacement cards by logging into your account at www.sanfordhealthplan.com. Information on creating an account is available at www.sanfordhealthplan.com/ndpers.

Conditions for Coverage

Members shall be entitled to coverage for the Health Care Services (listed in the "*Covered Services*," in Section 5) that are:

1. Medically Necessary and/or Preventive;
2. Received from or provided under the orders or direction of a Participating Provider;
3. Approved by the Plan, including Preauthorization/Prior Approval where required; and
4. Within the scope of health care benefits covered by the Plan.

However, the requirements to use Participating Providers and obtain preauthorization/prior approval do not apply to Emergency Conditions or Urgent Care Situations, both in and out of the Service Area. In such cases, services for Emergency Conditions and Urgent Care Situations will be covered if they are provided by a Non-Participating Provider.

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

Members are not required, but are strongly encouraged, to select a Primary Care Practitioner and/or Provider (PCP) and use that PCP to coordinate their Health Care Services.

In addition, all Health Care Services are subject to:

1. The exclusions and limitations described in Sections 5 and 6; and
2. Any applicable Copay, Deductible, and Coinsurance amounts as stated in this COI, your Summary of Benefits and Coverage (SBC), and your Summary of Pharmacy Benefits.

In-Network Coverage

In-Network coverage is provided under two (2) plan levels. For more information, see *Selecting a Health Care Provider* in Section 1. In-Network benefit payments pay according to coverage under:

1. Basic Plan; or
2. PPO Plan

NOTE: If you travel out of the Plan's Service Area for the purpose of seeking medical treatment outside the Plan's Service Area, as defined in this COI, without Preauthorization/Prior Approval for a service that requires such authorization/approval, your claims will be paid according to the Basic Plan benefits and stipulations set forth in Section 1. Additionally, the Member will receive the Basic Plan benefits if: 1) a PPO Health Care Provider is not available in the Member's area; or 2) if the Member either chooses or is referred to a Health Care Provider not participating in the Preferred Provider Organization (PPO).

Appropriate Access

Primary Care Practitioner and Hospital Providers

Appropriate access for Primary Care Practitioners and/or Providers and Hospital Provider sites is within *fifty (50)* miles of a Member's city of legal residence.

Specialty Practitioners and Other Providers

For other Participating Practitioners and Providers such as Specialty Physicians, Diagnostic Service Centers, Nursing Homes, and Rehabilitation Providers, appropriate access is within *fifty (50)* miles of a Member's city of legal residence. Appropriate access includes access to Participating Practitioners and Providers when the Member has traveled outside of the Service Area. If you are traveling within the Service Area where other Participating Practitioners and Providers are available then you must use Participating Practitioners and Providers.

Members who live outside of the Plan's Service Area must use the Plan's contracted Network of Participating Practitioners and Providers as indicated in the Plan's Provider Directory. Members who live outside the Service Area will receive Identification Cards that display their network logo along with instructions on how to access this Network. If a Member chooses to go to a Non-Participating Practitioner or Provider when appropriate access (within *fifty (50)* miles of a Member's city of legal residence) is available, claims will be processed at the Basic Plan (Out-of-Network) level.

Transplant Services

Transplant Services must be performed at designated Plan Participating centers of excellence and are not subject to Appropriate Access standards as outlined above. Transplant coverage includes related post-surgical treatment, medications, 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.

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Case Management

Case management is a collaborative process that assesses, plans, implements, coordinates, monitors and evaluates the options and services required to meet an individual's health needs, using communication and available resources to promote quality, cost effective outcomes.

Cases are identified for possible case management, based on a request for review or the presence of a number of parameters, such as:

a. admissions that exceed the recommended or approved length of stay;
b. utilization of health care services that generates ongoing and/or excessively high costs;
c. conditions that are known to require extensive and/or long term follow up care and/or treatment.

Sanford Health Plan's case management process allows professional case managers to assist Members with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans.

In consultation with case managers, Sanford Health Plan may approve coverage that extends beyond the limited time period and/or scope of treatment initially approved. This consultation also includes utilization management processes as described below.

All decisions made through case management are based on the individual circumstances of a Member's case. Each case is reviewed on its own merits by appropriate health plan medical professionals to ensure the best health outcome(s) of the Member.

Utilization Review Process – OVERVIEW

The Plan's Utilization Management Department is available between the hours of 8:00am and 5:00pm Central Time, Monday through Friday, by calling the Plan's toll-free number 1-888-315-0885 or TTY/TDD: 1-877-652-1844 (toll-free). After business hours, you may leave a confidential voicemail for the Utilization Management Department and someone will return your call on the next business day. You can also fax the Plan at (605) 328-6813. The date of receipt for Non-Urgent Requests received outside of normal business hours will be the next business day. The date of receipt for Urgent Requests will be the actual date of receipt, whether or not it is during normal business hours. All Utilization Management Adverse Determinations will be made by the Sanford Health Plan Chief Medical Officer or appropriate Practitioner. All benefit Adverse Determinations will be made by a person assigned to coordinate the benefit, denial and Appeal process. **For detailed information on the below, see Section 8, *Problem Resolution.***

Prospective (Pre-service) Review of Services (Preauthorization/Prior Approval)

The Member is ultimately responsible for obtaining Preauthorization/Prior Approval from the Utilization Management Department in order to receive In-Network coverage. However, information provided by the Practitioner's office will also satisfy this requirement. Participating Health Care Practitioners and Providers have been given instructions on how to get the necessary authorizations/approvals for surgical procedures or hospitalizations/admissions you may need. Members are responsible to confirm with the Participating Practitioner and/or Provider that any required Plan Preauthorization/Prior Approval has been obtained.

Preauthorization/Prior Approval is the authorization/approval of a requested service prior to receiving the service. Preauthorization/Prior Approval (a pre-service determination) is designed to facilitate early identification of the treatment plan to ensure medical management and appropriate resources are provided throughout an episode of care. See *"Services that Require Prospective Review"* on the following pages.

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

Preauthorization/Prior Approval is required for all Inpatient Admissions of Members. This requirement applies but is not limited to the following:

1. Acute care Hospitalizations (including medical, surgical, and non-Emergency mental health and/or substance use disorder admissions);
2. Residential Treatment Facility Admissions; and
3. Rehabilitation center Admissions.

NOTE: Admissions and Hospitalizations require an overnight stay, as defined in Section 10. Admission before the day of non-Emergency surgery will not be authorized/approved unless the early admission is medically necessary and specifically approved by the Plan. Coverage for Hospital expenses prior to the day of surgery will be denied unless authorized/approved prior to being incurred.

Urgent Care Requests

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

Services that Require Prospective Review/Preauthorization/Prior Approval

1. Inpatient Hospital Admissions (includes Admissions for medical, surgical, mental health and/or substance use disorders);
2. Selected Outpatient Procedures including but not limited to:
   a. Covered Rhinoplasty Surgeries for Non-Cosmetic Reasons;
   b. Obstructive Sleep Apnea Treatment, except for Continuous Positive Airway Pressure (CPAP);
   c. Medically-Necessary Orthodontics;
3. Home Health, Hospice and Home IV therapy services;
4. Select Durable Medical Equipment (DME) including the below. For more details, see DME requiring Preauthorization/Prior Approval in Section 5(a):
   a. Prosthetic Limbs requiring replacement within 5 years;
   b. Insulin infusion devices;
   c. Insulin pumps;

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d. Continuous Glucose Monitoring Systems (CGM);
e. Electric wheelchairs;
5. Skilled nursing and sub-acute care;
6. Dental Anesthesia and Hospitalization for all Members age 9 and older;
7. Chronic Pain Management;
8. Transplant Services;
9. Infertility Services, including assisted reproductive technology for GIFT, ZIFT, ICSI and IVF;
10. Genetic Testing;
11. Osseointegrated implants, including Cochlear implants and bone-anchored (hearing aid) implants;
12. Select Specialty Medications including:
    a. Restricted Use Medications; and
    b. Growth Hormone Therapy/Treatment;
13. Bariatric Surgery; and
14. Referrals to Non-Participating Providers, which are recommended by Participating Providers. Preauthorization/Prior Approval is required for the purposes of receiving Basic Plan level coverage. If Preauthorization/Prior Approval is not obtained for referrals to Non-Participating Providers, the services will be covered at the Basic Plan level. Preauthorization/Prior Approval does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in this section.

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

All requests for Preauthorization/Prior Approval are to be made by the Member or Practitioner and/or Provider's office at least *three (3)* business days prior to the scheduled admission or requested service. For Non-Urgent preauthorization/prior approval requests, the Plan's Utilization Management Department may review a request for a period of up to fifteen (15) calendar days from the date of the request, provided that all information supporting the request has been received. The Utilization Management Department will review the Member's medical request against standard criteria.

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

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

You are ultimately responsible for obtaining Preauthorization/Prior Approval from the Utilization Management Department. Failure to obtain Preauthorization/Prior Approval may result in coverage at the Basic Level (see Section 1). However, information provided by the Practitioner and/or Provider's office also satisfies this requirement. Members are responsible to confirm with the Participating Practitioner and/or Provider that any required Plan Preauthorization/Prior Approval has been obtained.

For medical necessity requests: the Utilization Management Department will review the Member profile information against standard criteria. A determination for *elective inpatient or non-Urgent Care Situations* will be made by the Utilization Management Department *within fifteen (15) calendar days* of receipt of the request. If the Utilization Management Department is unable to make a decision *due to matters beyond its control*, it may extend the decision timeframe once, for up to *fifteen* (*15) calendar days*. Within *fifteen (15*) *calendar days* of the request for authorization/approval, Sanford Health Plan must notify the Member or Member's Authorized Representative of the need for an extension and the date by which it expects to make a decision.

For benefit determinations: a person assigned to coordinate the benefit, denial and Appeal process will review the request using standards established by the Plan and, if the request is approved, provide notification of the determination, or if the request is denied, provide notification of the denial and relevant appeal rights. A benefit determination will be made *within fifteen (15) calendar days* of receipt of the request. If the Plan 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/approval, Sanford Health Plan must notify the Member or Member's Authorized Representative of the need for an extension and the date by which it expects to make a decision.

Lack of Necessary Information

If the Plan is unable to make a decision *due to lack of necessary information*, it must notify the Member or the Member's Authorized Representative of what specific information is necessary to make the decision *within fifteen (15)* calendar days of the Prospective (Pre-service) Review request. Sanford Health Plan must give the Member or the Member's Authorized Representative 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 lieu of notifying the Member, the Plan may notify the Practitioner and/or Provider of the information needed, if the request for health care services came from the Practitioner and/or Provider.

The decision time period is suspended, and the Plan shall have the remainder of the fifteen (15) calendar days from receipt of the request for

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authorization/approval to consider the request, measured from the earlier of the date in which the Plan receives additional information from the Member or Practitioner or *forty-five (45)* days after the notification to the Member or Practitioner. The Prospective (Pre-service) Review determination shall either be Preauthorization/Prior Approval of the requested service, or additional review will be needed by the Plan Chief Medical Officer; however, the decision will be made within *fifteen (15) calendar* days of that date. If the information is not received by the end of *the forty-five (45) calendar* day extension, Sanford Health Plan will deny the request.

If the Plan receives a request that fails to meet the procedures for Prospective (Pre-service) Review requests, the Plan will notify the Practitioner or Member of the failure, and proper procedures to be followed, as soon as possible but no later than *five (5)* calendar days after the date of the failure. Notification may be oral unless the Practitioner or Member request written notification.

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

If the Plan's determination is an Adverse Determination, the Plan shall provide written notice in accordance with the *Written Notification Process for Adverse Determinations* procedure below. At this point, the Member can request an Appeal of Adverse Determinations. Refer to "*Problem Resolution*" in Section 8 for details.

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

An **Emergency Medical Condition** is a medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any 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..

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

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

If an Urgent Care Situation occurs, Members should contact their Primary Care Provider immediately, if one has been selected, and follow his or her instructions. A Member may always go directly to a participating urgent care or after-hours clinic. In determining whether a request is "Urgent," the Plan shall apply the judgment of a Prudent Layperson that possesses an average knowledge of health and medicine, as defined in Section 10. When a Practitioner with knowledge of the Member's medical condition determines a request to be an Urgent Care Situation, the Plan shall treat such a request as an Urgent Care Request.

NOTE: Prospective (Pre-service) Review (Preauthorization/Prior Approval) is not required for maternity admissions, Emergency Medical Conditions or Urgent Care Situations. However, the Plan must be notified by the Member as soon as reasonably possible and no later than *forty-eight (48)* hours after the Member is physically or mentally able to do so. A Member's Authorized Representative may notify the Plan on the Member's behalf with written permission of the Member.

For Urgent Care Requests (Prospective (Pre-service) Reviews): the determination for medical care, including care for behavioral, mental health, and/or substance use disorders will be made by the Utilization Management Department as soon as possible (taking into account medical exigencies), but no later than *seventy-two (72) hours* after receipt of the request. Notification of the determination will be made to the Member or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service via telephone by the Utilization Management Department as soon as possible but no later than within *seventy-two (72) hours* of receipt of the request. For authorizations/approvals and Adverse Determinations, the Plan will give electronic or written notification of the decision to the Member or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service as soon as possible (taking into account medical exigencies) but no later than within *three (3)* calendar days of the telephone notification.

Lack of Necessary Information

If the Plan is unable to make a decision due to lack of necessary information, it may extend the decision timeframe once for up to *forty-eight (48) hours* to request additional information. Within *twenty-four (24) hours* after receipt of the request, the Plan will notify the Member or the Member's Authorized Representative of what specific information is necessary to make the decision. In lieu of notifying the Member, the Plan can notify the Practitioner of the information needed if the request for health care services came from the Practitioner. Sanford Health Plan must give the Member or the Member's Authorized Representative a reasonable amount of time taking into account the circumstances, but not less than *forty-eight (48) hours* to provide the specified information. If the Plan receives a request that fails to meet the procedures for Urgent Prospective (Pre-service) Review requests, the Plan will notify the Practitioner and Member of the failure and proper procedures to be followed as soon as possible but no later than *twenty-four (24) hours* after the date of the failure. Notification may be oral unless the Practitioner or Member request written notification. The Member, or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service will be notified by telephone of the Plan's determination as soon as possible but no later than forty-eight (48) hours after the earlier of: 1) the Plan's receipt of the requested information or 2) the end of the period provided to submit the requested information. The Plan will also give electronic or written notification of the decision as soon as possible but no later than within *three (3)* calendar days of the telephone notification. Failure to submit necessary information is grounds for denial of authorization/approval.

If the Plan's determination is an Adverse Determination, the Plan shall provide written notice in accordance with the *Written Notification Process for Adverse Determinations* procedure below. At this point, the Member can request an Appeal of Adverse Determinations. Refer to "*Problem Resolution*" in Section 8 for details.

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Concurrent Review Process for Medical Care Requests

Concurrent Review is utilized for medical care, including care for behavioral, mental health, and/or substance use disorders when a request for an extension of an approved ongoing course of treatment over a period of time or number of treatments is warranted. Additional stay days must meet the continued stay review criteria and, if acute levels of care criteria are not met, a decision to authorize/approve further treatment must be made at that time. Preauthorization/Prior Approval of inpatient health care stays will terminate on the date the Member is to be discharged from the Hospital or Facility (as ordered by the attending Practitioner). Hospital/Facility days accumulated beyond the ordered discharge date will not be authorized/approved unless the continued stay criteria continue to be met. Charges by Practitioners and/or Providers associated with these non-authorized/approved days are non-covered.

The health care service or treatment that is the subject of the Adverse Determination shall be continued without liability to the Member until the Member has been notified of the determination by the Plan with respect to the internal review request made pursuant to the Plan's Appeal Procedures. Any reduction or termination by the Plan during the course of treatment before the end of the period or number treatments shall constitute an Adverse Determination. For requests to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the Plan shall make an urgent Concurrent determination and notify the Member, or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service by telephone of the determination as soon as possible taking into account the Member's medical condition but in no event more than twenty-four (24) hours after the date of the Plan's receipt of the request.

The Plan will provide electronic or written notification of an authorization/approval to the Member or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service within *three (3) calendar* days after the telephone notification. The Plan shall provide written or electronic notification of the Adverse Determination to the Member or the Member's Authorized Representative and those Providers involved in the provision of the service sufficiently in advance (but no later than within *three (3) calendar* days of the telephone notification) of the reduction or termination to allow the Member or, the Member's Authorized Representative to file an Appeal request to review of the Adverse Determination and obtain a determination with respect to that review before the benefit is reduced or terminated.

In cases where the Member is not at financial risk, Members will not be notified of an Adverse Determination. Members will be notified in all other cases.

Urgent Concurrent Reviews Requested Within Twenty-Four (24) Hours of Expiring Authorization/Approval

If the request to extend Urgent Concurrent Review is not made at least *twenty-four (24) hours* prior to the expiration of the prescribed period of time, or number of treatments for medical care, including care for behavioral, mental health, and/or substance use disorders, Sanford Health Plan will treat it as an Urgent Prospective (Pre-service) Review decision and make the decision as soon as possible (taking into account the medical exigencies) but no later than *seventy-two (72) hours* after the request. For authorizations/approvals and denials, the Plan will give telephone notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service within *seventy-two (72) hours* of receipt of the request. The Plan will give written or electronic notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service as soon as possible but no later than within *three (3) calendar* days of the telephone notification.

If the Plan's determination is an Adverse Determination, the Plan shall provide written notice in accordance with the *Written Notification Process for Adverse Determinations* procedures outlined below. At this point, the Member can request an Appeal of Adverse Determination. Refer to the "*Problem Resolution*" in Section 8 for details.

Retrospective (Post-service) Review Process for Medical Care Requests

Retrospective (Post-service) Review is used by Sanford Health Plan for medical care, including care for behavioral, mental health, and/or substance use disorders to review services that have already been utilized by the Member where such services have not involved a Prospective (Pre-service) Review request, and where the review is not limited to the veracity of documentation, accuracy of coding, or adjudication for payment. The Plan will review the request and make the decision to approve or deny within *thirty (30)* calendar days of receipt of the request. Written or electronic notification will be made to the Member, Practitioner and those Providers involved in the provision of the service within *thirty (30) calendar* days of receipt of the request. In cases where the Member is not at financial risk, Members will not be notified of an Adverse Determination. Members will be notified in all other cases.

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

Lack of Necessary Information

If the Utilization Management Department is unable to make a decision due to lack of necessary information, it must notify the Member or the Member's Authorized Representative of what specific information is necessary to make the decision within *thirty (30) calendar* days of the Retrospective (Post-service) Review request. Sanford Health Plan must give the Member or the Member's Authorized Representative *forty-five (45)* calendar days to provide the specified information. In lieu of notifying the Member, the Plan can notify the Practitioner of the information needed if the request for health care services came from the Practitioner.

The decision time period is suspended from the date of the notification to the Member or Practitioner as applicable, until the earlier of the date on which the Plan receives any information from the Member or Practitioner or *forty-five (45)* days after the notification to the Member or Practitioner. A decision and written or electronic notification to the Member, Practitioner and those Providers involved in the provision of the service will be made within *fifteen (15)* calendar days of that date. If the information is not received by the end of the *forty-five (45)* calendar day extension Sanford Health Plan will issue an Adverse Determination and written or electronic notification will be made to the Member, Practitioner and those Providers involved in the provision of the service within *fifteen (15)* calendar days.

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If the Plan's determination is an Adverse Determination, the Plan shall provide written notice in accordance with the *Written Notification Process for Adverse Determinations* procedure below. At this point, the Member can request an Appeal of Adverse Determinations. Refer to the "Problem Resolution" in Section 8 for details.

Written Notification Process for Adverse Determinations

The written notifications for Adverse Determinations will include the following:

1. The specific reason for the Adverse Determination in easily understandable language.
2. Reference to the specific internal plan rule, provision, guideline, or protocol on which the determination was based and notification that the Member will be provided a copy of the actual plan provisions, guidelines, and protocols free of charge upon request. 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.
3. If the Adverse Determination is regarding coverage for a mental health and/or substance use disorder, a statement notifying members 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 Member failing to submit necessary information, the notice shall include, a description of any additional material or information which the Member 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 Member's medical circumstances or a statement that an explanation will be provided to the Member 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 business days of a Member/Member's 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 the Mental Health Parity and Addiction Equity Act of 2008 (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 must be included in the letter. If there is insufficient clinical information to reference a specific clinical practice guideline or policy, the letter must state the inability to reference the specific criteria and must describe the information needed to render a decision.
8. A description of the Plan's Appeal procedures including how to obtain an expedited review if necessary and any time limits applicable to those procedures, the right to submit written comments, documents or other information relevant to the appeal; an explanation of the Appeal process including the right to member representation; how to obtain an Expedited review if necessary and any time limits applicable to those procedures; notification that Expedited External Review can occur concurrently with the internal Appeal process for urgent care/ongoing treatment; and the timeframe the Member 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 appropriate Practitioner and/or Provider to discuss the determination.
10. If a determination is adverse, the right to bring a civil action in a court of competent jurisdiction.
11. To contact the North Dakota Insurance Commissioner at any time at:
    North Dakota Insurance Department
    600 E. Boulevard Ave.
    Bismarck, ND 58505-0320
    Email: insurance@nd.gov
    Consumer hotline: (800) 247-0560 (toll-free)
    TTY: (800) 366-6888 (toll-free)

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Section 5. Covered Services – OVERVIEW

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Section 5(a) Medical services and supplies provided by health care Practitioners and Providers

IMPORTANT

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

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.

Be sure to read Section 4, "How you get care", for valuable information about conditions for coverage.

You or your Practitioner and/or Provider must get Preauthorization/Prior Approval of some services in this Section. The benefit description will say "**NOTE:** Preauthorization/Prior Approval is required" for certain services.

Failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits (See Services requiring Preauthorization/Prior Approval in Section 4.)

IMPORTANT

Benefit Description

Diagnostic and treatment services

We cover professional services from Practitioners, Providers, Physicians, Nurse Practitioners, and Physician's Assistants in a Practitioner and/or Provider's office, an urgent care center; as well as medical office consultations, and second surgical opinions.

NOTE: You or your Practitioner and/or Provider must get Preauthorization/Prior Approval of the following services; Failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits (See Services requiring Preauthorization/Prior Approval in Section 4.):

- Inpatient Hospital stays, Outpatient surgical procedures, and Skilled Nursing Facility stays

Lab, x-ray and other diagnostic test coverage includes:

• Blood tests	• Pathology	• CT Scans/MRI
• Urinalysis	• X-rays	• Ultrasound
• Non-routine PAP tests	• PET Scans	• Electrocardiogram (EKG)
• Non-routine PSA tests	• DEXA Scans	• Electroencephalography (EEG)
	• Non-routine mammograms	

Not Covered: *Thermograms or thermography*

Preventive care, adults & children

NOTE: The Plan will pay up to a Maximum Benefit Allowance of $200 per Member per Benefit Period for any *non-routine screening services* not listed below or not recommended with a rating of "A" or "B" by the United States Preventive Services Task Force. Such *non-routine screening services* will be subject to Copayment, Deductible and Coinsurance amounts after the $200 Benefit Allowance has been met.

A Health Care Provider will counsel Members as to how often preventive services are need based on the age, gender and medical status of the Member. Services include:

- **Well Child Care to the Member's 6th birthday**
  - Seven (7) visits for Members from birth through 12 months;
  - Three (3) visits for Members from 13 months through 24 months; and
  - One (1) visit per Benefit Period for Members 25 months through 72 months.
- **Well Child Care Immunizations to the Member's 6th Birthday**
  - Covered immunizations are those that have been published as policy by the Centers for Disease Control, including DPT (Diphtheria-Pertussis-Tetanus), MMR (Measles-Mumps-Rubella), Hemophilus, Influenza B, Hepatitis, Polio, Varicella (Chicken Pox), Pneumococcal Disease, Influenza Virus.
- **Preventive Screening Services for Members age 6 and older**
  - One routine physical examination per Member per Benefit Period.
  - Routine diagnostic screenings.
  - Routine screening procedures for cancer.
- **Mammography Screening Services for Members between ages 35 and 40**
  - One (1) screening service for Members between the ages of 35 and 40
- **Mammography Screening Services for Members age 40 and older**
  - One (1) screening service per year per Member
- **Routine Pap Smear**
  - One (1) Pap smear per Member per Benefit Period. Office Visit Copay applies.
  - Additional benefits will be available for Pap smears when Medically Necessary and ordered by a Professional Health Care Provider

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- **Prostate Cancer Screening for Asymptomatic Males Ages 50 and Older, and Males Ages 40 with a Family History of Prostate Cancer**
    - One (1) digital rectal examination annually per Member. Office Visit Copay applies.
    - One (1) prostate-specific antigen test annually per Member. Office Visit Copay applies.
    - Additional benefits will be available for prostate cancer screening when Medically Necessary and ordered by a Professional Health Care Provider.
- **Fecal Occult Blood Testing for Colorectal Cancer Screening for Members age 50 and older**
    - One (1) test per Member per benefit period
- **Immunizations other than Well Child Care**
    - Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including Tetanus, Influenza Virus, Pneumococcal Pneumonia, MMR (Measles-Mumps-Rubella), Varicella (Chicken Pox), Shingles (Zoster), Meningococcal Disease, and Human Papillomavirus (HPV). Certain age restrictions may apply.

Not Covered:

- *Physical examinations, including but not limited to: pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for drivers' licenses)*
- *Virtual colonoscopies*

Maternity care

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

Covered maternity services include:

- Screening for gestational diabetes mellitus during pregnancy
    - Testing includes a screening blood sugar followed by a glucose tolerance test if the sugar is high.
    - Outpatient Nutrition Care Services available for gestational diabetes and diabetes mellitus. See
- Anemia screening
- Bacteruria (bacteria in urine) screening
- Hepatitis B screening
- Rh (Rhesus) incompatibility screening: first pregnancy visit and 24-28 weeks gestation
- Genetic counseling or testing that has in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force unless excluded under "Not Covered" conditions below. *Preauthorization/Prior Approval is required*.
- Reproductive Health Care Services unless prohibited by the laws of This State, per plan guidelines.
- Prenatal vitamins without Cost Sharing if 1) prescribed by a Practitioner; and 2) Member is enrolled in Sanford Health Plan's *Healthy Pregnancy Program*.
- Deductible for delivery services is waived if services are rendered at a PPO Provider, and the Member is enrolled in Sanford Health Plan's *Healthy Pregnancy Program*.

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

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

NOTE: We encourage you to participate in our *Healthy Pregnancy Program*; Call toll-free 1-888-315-0885 | TTY/TDD: 1-877-652-1844 (toll-free) to enroll.

Not Covered:

- *Amniocentesis or chorionic villi sampling (CVS) solely for sex determination.*
- *Genetic testing when performed in the absence of symptoms or high risk factors for a heritable disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices; genetic testing that has been performed in response to direct-to-consumer marketing and not under the direction of the Member's Practitioner and/or Provider.*

Healthy Pregnancy Program – DETAILS

The *Healthy Pregnancy Program* is designed to identify women at higher risk for premature birth and to prevent the incidence of preterm birth through assessment, intervention and education. Participation in the *Healthy Pregnancy Program* is voluntary and free to all Members in the Plan.

To enroll, call Sanford Health Plan's Care Management Department at 1-888-315-0885 *(toll-free)* | TTY/TDD: 1-877-652-1844 *(toll-free)* after the first prenatal visit, preferably before the 12th week and no later than the 34th week. You may also send a secure message to the Plan through by logging into your account at www.sanfordhealthplan.com, and a representative from the Care Management Department will contact you to complete your enrollment in the program.

Enrolling in the Healthy Pregnancy Program is easy and free to the Member. When a Member enrolls, a Case Manager will review a brief

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preterm labor risk assessment questionnaire with the Member. To complete this questionnaire, Members will need their Member ID number; Professional Health Care Provider's name, address and telephone number; and expected due date. As a program participant, the Member will receive information concerning pregnancy and prenatal care.

NOTE: When a Member is enrolled under the Healthy Pregnancy Program, the Deductible Amount is waived for delivery services received from a PPO Health Care Provider. Copayment and Coinsurance Amounts for prenatal vitamins are also waived when the Member is enrolled in the Healthy Pregnancy Program.

Newborn care

A newborn is eligible to be covered from birth. Members must complete and sign the Plan's enrollment application form requesting coverage for the newborn within *thirty-one (31)* days of the infant's birth. For more information, see Section 3 on Enrollment and "*When and How Dependent Coverage Begins"*.

We cover care for the enrolled newborn child from the moment of birth including care and treatment for illness, injury, premature birth and medically diagnosed congenital defects and birth abnormalities (Please refer to "Reconstructive Surgery" in Section 5(a) for coverage information of surgery to correct congenital defects).

Not Covered: *Newborn delivery and nursery charges for adopted dependents prior to the adoption-bonding period (See Section 3, "When and How Dependent Coverage Begins.")*

Infertility services

NOTE: Preauthorization/Prior Approval is required; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

Benefits are available for services, supplies and medications related to artificial insemination (AI) and assisted reproductive technology (ART); includes gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), intracytoplasmic sperm injection (ICSI), or in-vitro fertilization (IVF). *Prior Approval is required for assisted reproductive technology for GIFT, ZIFT, ICSI and IVF.*

NOTE: Benefits are subject to a $500 Lifetime Infertility Services Deductible Amount and a $20,000 Lifetime Maximum per Member. This Coinsurance Amount and the Infertility Services Deductible Amount do not apply toward the Out-of-Pocket Maximum Amount.

Not Covered:

- *Donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of unfertilized sperm or eggs; Surrogate pregnancy and delivery; Gestational Carrier pregnancy and delivery; and preimplantation genetic diagnosis testing;*
- *Genetic testing when performed in the absence of symptoms or high risk factors for a heritable disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices; genetic testing that has been performed in response to direct-to-consumer marketing and not under the direction of the Member's Practitioner and/or Provider;*
- *Reversals of prior sterilization procedures; and*
- *Any expenses related to surrogate parenting.*

Allergy care

- Testing and treatment
- Allergy injections
- Allergy serum

Not Covered:

- *The following allergy testing modalities: nasal challenge testing, provocative/neutralization testing for food and food additive allergies, leukocyte histamine release, Rebuck skin window test, passive transfer or Prausnitz-Kustner test, cytotoxic food testing, metabisulfite testing, candidiasis hypersensitivity syndrome testing, IgG level testing for food allergies, general volatile organic screening test and mauve urine test.*
- *Methods of desensitization treatment: provocation/neutralization therapy for food/chemical or inhalant allergies by sublingual, intradermal and subcutaneous routes, Urine Autoinjections, Repository Emulsion Therapy, Candidiasis Hypersensitivity Syndrome Treatment or IV Vitamin C Therapy.*
- *Clinical ecology, orthomolecular therapy, vitamins or dietary nutritional supplements, or related testing provided on an inpatient or outpatient basis.*

Dialysis

Dialysis for renal disease, unless or until the Member qualifies for federally funded dialysis services under the End Stage Renal Disease (ESRD) program. Services include equipment, training, and medical supplies required for effective dialysis care. See *Outpatient Nutrition Care Services* in this Section for additional Chronic Renal Failure benefits. Coordination of Benefit (COB) Provisions apply. For more information on COB, please see Section 9.

Treatment therapies

- Inhalation Therapy
- Radiation Therapy
- Chemotherapy, regardless of whether the Member has separate prescription drug benefit coverage
- Pheresis Therapy

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Diabetes supplies, equipment, and education

- Blood glucose monitors, including continuous glucose monitoring systems (CGM), *Preauthorization/Prior Approval is required*
- Blood glucose monitors for the legally blind
- Test strips for glucose monitors
- Urine testing strips
- Insulin injection aids
- Lancets and lancet devices
- Insulin pumps and all supplies for the pump, *Preauthorization/Prior Approval is required*
- Routine foot care, including toe nail trimming
- Syringes
- Insulin infusion devices, *Preauthorization/Prior Approval is required*
- 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
- Prescribed oral agents for controlling blood sugars
- Glucose agents
- Glucagon kits
- Insulin measurement and administration aids for the visually impaired and other medical devices for the treatment of diabetes
- Dilated Eye Examination, limited to one (1) examination per Member per Benefit Period

Diabetes self-management training and education services 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 or the North Dakota Department on Health.

Not Covered: *Food items for medical nutrition therapy*

Outpatient rehabilitative and habilitative therapy services

Coverage is as follows for outpatient rehabilitative and habilitative therapy services, which include the management of limitations and disabilities, and services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function:

- **Physical Therapy:** Benefits are subject to medical necessity and performed by or under the direct supervision of a licensed Physical Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Occupational Therapy:** Benefits are available for 90 consecutive calendar days, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Necessary. Benefits are available when performed by or under the direct supervision of a licensed Occupational Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Speech Therapy:** Benefits are available for 90 consecutive calendar days, beginning on the date of the first therapy treatment for the condition. Additional benefits may be allowed after the 90 days when Medically Necessary. Benefits are available when performed by or under the direct supervision of a certified and licensed Speech Therapist. Services must be provided in accordance with a prescribed plan of treatment ordered by a Professional Health Care Provider.
- **Respiratory/Pulmonary Therapy:** Available when services are performed by or under the direct supervision of a registered respiratory care practitioner for the treatment, management, control and care of Members with deficiencies and abnormalities of the cardiorespiratory system. Services must be provided in accordance with an order from a Professional Health Care Provider.
- **Cardiac Rehabilitation Services:** Cardiac Rehabilitation Services must begin within 2 months following discharge from the Hospital. Twelve (12) visits per Member per episode, limited to the following diagnosed medical conditions:
  - Myocardial Infarction
  - Coronary Artery Bypass Surgery
  - Coronary Angioplasty and Stenting
  - Heart Valve Surgery
  - Heart Transplant Surgery

Not Covered:

- *Traction services*
- *Educational or non-medical services for learning disabilities and/or behavioral problems, including those educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)*
- *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, to prevent symptomatic deterioration or initiated by Members without symptoms in order to promote health and to prevent further problems*
- *Services provided in the Member's home for convenience*
- *Hot/cold pack therapy including polar ice therapy and water circulating devices*

Phenylketonuria

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

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Not Covered:

- *PKU dietary desserts and snack items*
- *Low protein modified food products or medical food for PKU to the extent those benefits are available under a Department of Health program or other state agency*

Amino acid-based elemental oral formulas

Coverage for 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 Department of Health program or other state agency*

Outpatient nutrition care services

Benefits are available for the following medical conditions:

- **Hyperlipidemia** – Maximum Benefit Allowance of 2 Office Visits per Member per Benefit Period.
- **Gestational Diabetes** – Maximum Benefit Allowance of 2 Office Visits per Member per Benefit Period.
- **Chronic Renal Failure** – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- **Diabetes Mellitus** – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- **Anorexia Nervosa** – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- **Bulimia** – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.
- **PKU** – Maximum Benefit Allowance of 4 Office Visits per Member per Benefit Period.

Not Covered:

- *Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management*
- *Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics*

Hearing services (testing, treatment, and supplies)

- Hearing services coverage is limited to diagnostic testing and treatment related to acute illness or injury only.
- Hearing aids for Members under age 18.
- Cochlear implants and bone-anchored (hearing aid) implants. *(Preauthorization/Prior Approval required)*

Not Covered:

- *Gradual hearing loss that occurs with aging and related adult hearing screening services, testing and supplies*
- *Hearing aids, unless for Members under age 18; non-implant devices; or equipment to correct hearing impairment or loss*
- *Tinnitus Maskers*
- *All other hearing related supplies, purchases, examinations, testing or fittings*

Vision services (testing, treatment, and supplies)

- Eyeglasses or contact lenses for Members diagnosed with aphakia (the absence of the lens of the eye, due to surgical removal, a perforated wound or ulcer, or a congenital condition resulting in complications which include the detachment of the vitreous or retina, and glaucoma)
- Non-routine vision exams relating to disease or injury of the eye
- Eyeglasses, including lenses and one frame per lifetime up to up to a net allowance of $200 or clear contact lenses for the aphakia eye will be covered for *two (2)* single lens per calendar year
- Scleral Shells: Soft shells limited to *two (2)* per calendar year. Hard shells limited to *one (1)* per lifetime
- Cataract Surgery
- One (1) pair of eyeglasses or contact lenses per Member when purchased within 6 months following a covered cataract surgery the surgery
- Visual Training for Members under age 10. Benefits are subject to an Annual Maximum of 16 visits per Member.

Not Covered:

- *Adult vision exams (routine)*
- *Eyeglasses or contact lenses and the vision examination for prescribing or fitting eyeglasses or contact lenses, unless specified as Covered elsewhere in this Certificate of Insurance*
- *Refractive errors of the eye*
- *Refractive eye surgery when used in otherwise healthy eyes to replace eyeglasses or contact lenses*
- *Purchase, examination, or fitting of eyeglasses or contact lenses, except as specifically covered elsewhere*
- *Radial Keratotomy, Myopic Keratomileusis, and any surgery involving corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error*
- *Replacement of lost, stolen, broken, or damaged lenses or glasses*
- *Bifocal contact lenses*

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- *Special lens coating or lens treatments for prosthetic eyewear*
- *Routine cleaning of Scleral Shells*

Foot care

Routine foot care covered for Members with diabetes only. See Section 5(a) *Diabetes supplies, equipment, and education* for more information on Plan policies.

Non-routine diagnostic testing and treatment of the foot due to illness or injury

NOTE: See Section on *Orthotic and prosthetic devices* for information on podiatric shoe inserts

Not Covered:

- *Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized/approved corrective surgery (except as stated above and in Section 5(a) Supplies, equipment, and education for Diabetes)*
- *Diagnosis and treatment of weak, strained, or flat feet*

Orthotic and prosthetic devices

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

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

Adjustments and/or modification to the prosthesis required by wear/tear, due to a change in Member's condition, or to improve its function are eligible for coverage and do not require Preauthorization/Prior Approval.

Repairs necessary to make the prosthetic functional are covered and do not require authorization/approval. The expense for repairs is not to exceed the estimated expense of purchasing another prosthesis.

NOTE: The following requires Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.):

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

NOTE: Internal prosthetic devices are paid as Hospital benefits; see Section 5(b) for payment information. Insertion of the device is paid under the surgery benefit.

Not Covered:

- *Experimental and/or Investigational services or devices*
- *Revision/replacement of prosthetics (except as noted per Plan guidelines (available upon request))*
- *Replacement or repair of items, if the items are damaged or destroyed by the Member's misuse, abuse or carelessness, lost, or stolen*
- *Duplicate or similar items*
- *Service call charges, labor charges, charges for repair estimates*
- *Wigs, cranial prosthesis, or hair transplants*
- *Cleaning and polishing of prosthetic eye(s)*

Durable medical equipment (DME)

Covered DME equipment prescribed by an attending 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 Certificate of Insurance guidelines apply (available upon request).

Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Plan guidelines (available upon request).

The following DME require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.):

- Respiratory equipment such as ventilators, pleural catheters, hand-held battery operated nebulizers, and suction pumps
- Gastrointestinal equipment such as TPN enteral supplies and formula, parenteral nutrition, and suction pumps
- Beds such as Hospital beds and mattresses
- Musculoskeletal equipment such as neuromuscular stimulators, and bone growth stimulators
- Integumentary supplies such as wound vacuum systems
- Wheelchairs
- Home IV therapy supplies and medications
- Repair, replacement, and periodic maintenance of durable medical equipment

NOTE: This list is not all-inclusive and is subject to change per Certificate of Insurance updates.

Not Covered:

- *Home Traction Units*
- *Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliance, except if covered elsewhere in this Certificate of Insurance*

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- *Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage*
- *Revision of durable medical equipment, except when made necessary by normal wear or use*
- *Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness; or if lost or stolen*
- *Duplicate or similar items*
- *Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates*
- *Items which are primarily educational in nature or for vocation, comfort, convenience or recreation*
- *Communication aids or devices to create, replace or augment communication abilities including, but not limited to, hearing aids unless for Members under age 18, speech processors, receivers, communication boards, or computer or electronic assisted communication*
- *Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools*
- *Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas*
- *Home Modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment*
- *Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier*
- *Remote control devices as optional accessories*
- *Any other equipment and supplies which the Plan determines are not eligible for coverage*

Home health services

NOTE: Preauthorization/Prior Approval is required; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)
Member must be home-bound to receive home health services. The following are covered if approved by the Plan in lieu of Hospital or Skilled Nursing Facility:

- part-time or intermittent care by a RN or LPN/LVN
- part-time or intermittent home health aide services for direct patient care only
- physical, occupational, speech, inhalation, and intravenous therapies up to the maximum benefit allowable
- medical supplies, prescribed medications, and lab services, to the extent they would be covered if the Member were Hospitalized

Not Covered:

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

Chiropractic services

Chiropractic services provided on an inpatient or outpatient basis when Medically Necessary as determined by Sanford Health Plan and within the scope of licensure and practice of a Chiropractor, to the extent services would be covered if provided by a Physician. Benefits are not available for maintenance care.

Not Covered:

- *Maintenance care*
- *Vitamins, minerals, therabands, cervical pillows, traction services, and hot/cold pack therapy including polar ice therapy and water circulating devices*

Reconstructive surgery

NOTE: The following services require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

- Surgery to restore bodily function or correct a deformity caused by illness or injury
- If you have had or are going to have a mastectomy, you may be entitled to certain benefits under 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 Practitioner and/or Provider and Member. Coverage will be provided for reconstructive breast surgery and physical complications at all stages of a mastectomy, including lymphedema for those Members who had a mastectomy resultant from a disease, illness, or injury. For single mastectomy: coverage extends to the non-affected side to make it symmetrical with the affected breast post-surgical reconstruction. Breast prostheses and surgical bras and replacements are also covered (see Prosthetic devices in Section 5(a)). Deductible and coinsurance applies as outlined in your *Summary of Benefits and Coverage*.

Not Covered:

- *Surgeries related to gender transformation/gender reassignment*
- *Cosmetic Services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services*
- *Removal, revision or re-implantation of saline or silicone implants for: breast implant malposition; unsatisfactory aesthetic outcome; patient desire for change of implant; patient fear of possible negative health effects; or removal of ruptured saline implants that do not meet medical necessity criteria*
- *Prophylactic (preventive) surgeries (i.e. mastectomy, oophorectomy)*

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Oral and maxillofacial surgery

NOTE: The following services require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

- Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth
  - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
  - Care must be received within *six (6)* months of the occurrence
  - Associated radiology services are included
- Orthognathic Surgery per Plan guidelines (available upon request)
- Diagnosis and treatment for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) and TMJ splints and adjustments if your primary diagnosis is TMJ/TMD.
- Preauthorization/Prior Approval is required for dental anesthesia for Members over age nine (9) and/or Members with a developmental disability, as determined by a licensed Practitioner and/or Provider, which places such a person at serious risk.
- Coverage applies regardless of whether the services are provided in a Hospital or a dental office

NOTE: Dental care Anesthesia and Hospitalization for the extraction of teeth is covered for a Member who:

a. is a child under age nine (9); or
b. is severely disabled or otherwise suffers from a developmental disability, or
c. has high risk medical condition(s) as determined by a licensed Practitioner and/or Provider, which places such a person at serious risk.

Not Covered:

- *Routine dental care and treatment*
- *Natural teeth replacements including crowns, bridges, braces or implants*
- *Osseointegrated implant surgery (dental implants)*
- *Extraction of wisdom teeth*
- *Hospitalization for extraction of teeth except as stated above in this subsection*
- *Dental x-rays or dental appliances*
- *Shortening of the mandible or maxillae for cosmetic purposes*
- *Services and supplies related to ridge augmentation, implantology, and Preventive vestibuloplasty*
- *Dental appliances of any sort, including but not limited to bridges, braces, and retainers (except for appliances for treatment of TMJ/TMD)*

Transplant services

NOTE: Preauthorization/Prior Approval is required; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

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

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

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

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

Transplants that meet the United Network for Organ Sharing (UNOS) criteria and/or Plan COI requirements, and are performed at Plan Participating Providers or contracted Centers of Excellence, are covered for the following:

1. Small bowel transplants
2. Kidney transplants for End Stage Renal Disease
3. Cornea transplants for End Stage Renal Disease

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

Not Covered:

- *Transplant evaluations with no end organ complications*
- *Storage of stem cells, including storing umbilical cord blood of non-diseased persons, for possible future use*
- *Artificial organs, any transplant or transplant services not listed above*
- *Expenses incurred by a Member as a donor, unless the recipient is also a Member*
- *Costs related to locating and/or screening organ donors*
- *Donor expenses for complications that occur after sixty (60) days from the date the organ is removed, regardless of whether the donor is covered as a Member under this Plan*
- *Services, chemotherapy, radiation therapy (or any therapy that damaged the bone marrow), supplies, medications and aftercare for, or related to, artificial or non-human organ transplants*
- *Services, chemotherapy, supplies, medications and aftercare for or related to human organ transplants not specifically approved by the Plan's Chief Medical Officer or its designee*
- *Services, chemotherapy, supplies, medications and aftercare for, or related to, transplants performed at a non-Plan Participating Center of Excellence*
- *Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria*

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Anesthesia

We cover services of an anesthesiologist or other certified anesthesia Provider in connection with an authorized/approved procedure or treatment.

Concurrent services received while inpatient

Concurrent services including medical, surgical, maternity, Chemotherapy or Radiation Therapy provided during one inpatient stay by one Professional Health Care Provider. Benefits for concurrent services will be based on the Covered Service with the highest Allowance.

When two or more Professional Health Care Providers have attended the Member during one inpatient stay because the nature or severity of the Member's condition requires the skills of separate Professional Health Care Providers, benefits will be available for the Covered Service that carries the highest Allowance for the type of service provided by each Professional Health Care Provider, provided the service is Medically Appropriate and Necessary and would otherwise be a Covered Service under this Benefit Plan.

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Section 5(b) Services provided by a Hospital or other Facility

IMPORTANT

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

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.
- Participating Providers must provide or arrange your care, and you must be Hospitalized in a Participating Facility, per Plan guidelines.
- Mental Health and Substance Use Disorder benefits provided by a Hospital or other Facility are outlined in Section 5(d).
- Be sure to read Section 4, "How you get care", for valuable information about conditions for coverage.
- **YOU MUST GET PREAUTHORIZATION/PRIOR APPROVAL OF SOME OF THESE SERVICES**. See the benefits description below.

IMPORTANT

Benefit Description

Inpatient Hospital

NOTE: Preauthorization/Prior Approval is required; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

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 the Plan
- The administration of whole blood and blood plasma is a Covered Service. The purchase of whole blood and blood components is not covered unless such blood components are classified as medications in the *United States Pharmacopoeia*.
- Special diets during Hospitalization, when specifically ordered
- Other services, supplies, biologicals, and medications prescribed by a Practitioner and/or Provider during Hospitalization

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

Not Covered:

- *Take-home medications (Prescription medications provided to a Member at discharge are paid under the Prescription Drug Benefit. See Sections 2 and 5(e) for payment amount details.)*
- *Personal comfort items (telephone, television, guest meals and beds)*
- *Admissions to Hospitals performed only for the convenience of the Member, the Member's family, or the Member's Practitioner and/or Provider*
- *Custodial or Convalescent care*
- *Intermediate level or Domiciliary care*
- *Rest cures*
- *Services to assist in activities of daily living (ADLs)*

Outpatient Hospital or Ambulatory Surgical Center

NOTE: Preauthorization/Prior Approval is required; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

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

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

Not Covered:

- *Surgical procedures that can be done in a Practitioner office setting (i.e. vasectomy, toe nail removal)*
- *Blood and blood derivatives replaced by the Member*
- *Take-home medications (Prescription medications provided to a Member at discharge are paid under the Prescription Drug Benefit. See Sections 2 and 5(e) for payment amount details.)*

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Skilled Nursing Facility Benefits

NOTE: Preauthorization/Prior Approval is required; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

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

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

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

Not Covered:

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

Hospice Care

NOTE: Preauthorization/Prior Approval is required; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

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

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

The following Hospice Services are Covered Services:

a. Admission to a hospice Facility, Hospital, or Skilled Nursing Facility for room and board, supplies and services for pain management and other acute/chronic symptom management
b. In-home hospice care per Plan guidelines (available upon request)
c. 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
d. Social services under the direction of a Participating Provider
e. Psychological and dietary counseling
f. Physical or occupational therapy, as described under *Section 5(a)*
g. Consultation and Case Management services by a Participating Provider
h. Medical supplies, DME and medications prescribed by a Participating Provider
i. Expenses for Participating Providers for consultant or Case Management services, or for physical or occupational therapists, who are not Group Members of the hospice, to the extent of coverage for these services as listed in this *Section 5(a)*, but only where the hospice retains responsibility for the care of the Member

Not Covered:

- *Independent nursing, homemaker services, respite care*

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Section 5(c) Emergency services/accidents

IMPORTANT

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

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.

Be sure to read Section 4, "How you get care", for valuable information about conditions for coverage.

IMPORTANT

What is an Emergency Medical Condition?

An **Emergency Medical Condition** is the sudden and unexpected onset of a health condition that would lead a Prudent Layperson, acting reasonably, and possessing the average knowledge of health and medicine, to believe that the absence of immediate medical attention could 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. **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 Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or
2. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.

If an Urgent Care Situation occurs, Members should contact their Primary Care Practitioner and/or Provider immediately, if one has been selected, and follows his or her instructions. A Member may always go directly to a participating urgent care or after-hours clinic (listing available on request or visit www.sanfordhealthplan.com/ndpers).

The Health Plan covers worldwide Emergency services necessary to screen and stabilize Members without Preauthorization/Prior Approval in cases where a Prudent Layperson would reasonably believe that an Emergency Medical Condition existed. Network restrictions do not apply to Emergency services received by Practitioners and/or Providers outside of the United States.

Benefit Description

Emergency within the Sanford Health Plan Service Area

Emergency services from Basic Plan-level Providers will be covered at the same benefit and cost sharing level as services provided by PPO-level Providers. If the Plan determines the condition did not meet Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts will apply, and the Member is responsible for charges above the Reasonable Cost.

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

The Member or a designated relative or friend must notify the Plan and the Member's Primary Care 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 Member is physically or mentally able to do so.

The Health Plan covers Emergency services necessary to screen and stabilize Members without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that an Emergency Medical Condition existed. With respect to care obtained from a Non-Participating Provider within the Plan's Service Area, the Plan shall cover Emergency services necessary to screen and stabilize a Member and may not require Prospective (pre-service) Review of such services if a Prudent Layperson would have reasonably believed that use of a Participating Provider would result in a delay that would worsen the Emergency, or if a provision of federal, state, or local law requires the use of a specific Practitioner and/or Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

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

Emergency outside the Sanford Health Plan Service Area

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

Coverage will be provided for Emergency Medical Conditions outside of the Service Area at the Basic Plan benefit level unless the Member

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has traveled outside the Service Area for the purpose of receiving such treatment (then benefits will be payable at the Non-participating Provider level; see Section 1 for details).

If an Urgent Care Situation occurs when traveling outside of the Plan's Service Area, Members 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 Member should contact the Plan and follow the Plan's instructions. Coverage will be provided for Urgent Care Situations outside the Service Area at the Basic Plan level unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

NOTE: For non-Emergency medical care or non-Urgent Care Situations when traveling outside the Plan's Service Area, benefits will be payable at Basic level. For details, see *Non-participating Providers outside the Sanford Health Plan Service Area* in Section 1.

Ambulance and Transportation Services

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

a. Medically Necessary; and
b. To the nearest Participating Provider equipped to furnish the necessary Health Care Services, or as otherwise approved and arranged by the Plan.

Not Covered:

- *Reimbursement for personal transportation costs incurred while traveling to/from Practitioner and/or Provider visits or other health care services*
- *Transfers performed only for the convenience of the Member, the Member's family or the Member's Practitioner and/or Provider*
- *Services and/or travel expenses relating to a Non-Emergency Medical Condition*

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Section 5(d) Mental health and substance use disorder benefits

IMPORTANT

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

All benefits are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.

Be sure to read Section 4, "How you get care", for valuable information about conditions for coverage.

YOU MUST GET PREAUTHORIZATION/PRIOR APPROVAL OF SOME OF THESE SERVICES. See the benefits description below.

IMPORTANT

Benefit Description

Mental health benefits

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 disorders; 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:

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

For outpatient treatment services, the first five (5) hours of treatment of any calendar year will be covered at 100% (no charge).

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

Telephonic consultation for a Member diagnosed with depression and within twelve (12) weeks of starting antidepressant therapy per Plan guidelines (available upon request). Coverage limited to one (1) telephonic consult per Member per year for depression and one (1) telephonic consult for Attention Deficit Hyperactive Disorder (ADHD).

NOTE: Preauthorization/Prior Approval is required for these benefits. As with other medical/surgical benefits, failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4):

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

Not Covered:

- *Convalescent care*
- *Marriage or bereavement counseling; pastoral counseling; financial or legal counseling; and custodial care counseling*
- *Educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)*
- *Educational or non-medical services for learning disabilities and/or Behavioral problems*
- *Services related to environmental change*
- *Behavioral therapy, modification, or training, including Applied Behavioral Analysis (ABA)*
- *Milieu therapy*
- *Sensitivity training*

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Substance use disorder benefits

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
- 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 use disorder professionals
- Partial Hospitalization
- Intensive Outpatient Programs

For outpatient treatment services, the first five (5) visits of treatment of any calendar year will be covered at 100% (no charge).

NOTE: Preauthorization/Prior Approval is required for these benefits; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4):

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

Not Covered:

- *Confinement Services to hold or confine a Member under chemical influence when no Medically Necessary services are provided, regardless of where the services are received (e.g. detoxification centers)*
- *Methadone or Cyclazocine therapy not part of an approved treatment program*
- *Marriage or bereavement counseling; pastoral counseling; financial or legal counseling; and custodial care counseling*
- *Educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)*
- *Educational or non-medical services for learning disabilities or behavioral problems*
- *Services related to environmental change*
- *Milieu therapy*
- *Sensitivity training*
- *Domiciliary care or Maintenance Care*
- *Convalescent care*

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Section 5(e) Prescription drug and diabetes supplies benefits

IMPORTANT	**Here are some important things to keep in mind about these benefits:** We cover prescribed medications, as described in this Section. All benefits are subject to the definitions, limitations and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary. Be sure to read Section 4, "How you get care", for valuable information about conditions for coverage. **YOU MUST GET PREAUTHORIZATION/PRIOR APPROVAL OF SOME OF THESE SERVICES.** See the benefits description below.	IMPORTANT

- **Where you can obtain them.** You must fill the prescription at a Plan Participating pharmacy for Cost Sharing amounts to apply. A Member may be responsible for payment of the Cost Sharing Amounts at the time the Prescription Medication is dispensed. A Participating Pharmacy agrees not to charge or collect any amount from the Member that exceeds the Cost Sharing Amounts. All claims must be submitted by the Participating Pharmacy. If the Member submits a Claim for Benefits when services are received at a Non-Participating Pharmacy, charges in excess of the Allowed Charge are the Subscriber's responsibility.
- **Specialty Medications.** Some specialty medications may be obtained with a copay at a retail pharmacy and some medications must be obtained through The Plan's contracted specialty drug vendor. To enroll, and obtain prior-approval to join the Specialty/Injectable Drugs Program, call toll-free 1-888-315-0885. Please refer to your *Summary of Pharmacy Benefits* handbook for a complete listing of specialty medications that require Preauthorization/Prior Approval. A listing of Plan Participating pharmacies is available upon request or can be viewed at www.sanfordheatlhplan.com.
- **How you can obtain them.** You must present your ID card to the Plan Participating pharmacy; if you do not present your ID card to the Plan Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy. Additionally, if you choose to go to a Non-Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy.

  NOTE: If a Member receives Prescription Medications from a Non-participating Pharmacy, the Member is responsible for payment of the Prescription Order or refill in full at the time it is dispensed, and must submit appropriate reimbursement information to Sanford Health Plan. Payment for covered Prescription Medications will be sent to the Subscriber. Any charges in excess of the Allowed Charge are the Subscriber's responsibility.
- **We use a formulary.** Sanford Health Plan covers prescribed medications according to our Formulary. A formulary is a list of Prescription Medication Products, which are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modifications. Additional medications may be added or removed from the formulary throughout the year. Sanford Health Plan will notify you of any formulary changes. For a copy of the Plan formulary, contact Utilization Management toll-free at 1-888-315-0885 | TTY/TDD: 1-877-652-1844 (toll-free) or you can view the formulary online by logging into your account at www.sanfordhealthplan.com.
- **Exception to formulary.** The Plan will use appropriate pharmacists and Practitioner and/or Providers to consider exception requests and promptly grant an exception to the drug formulary, including exceptions for anti-psychotic and other mental health medications, for a Member when the health care Practitioner and/or Provider prescribing the drug indicates to the health plan company that:
  1. the formulary drug causes an adverse reaction in the patient;
  2. the formulary drug is contraindicated for the patient; or
  3. the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

  NOTE: Members must generally try formulary medications before an exception for the formulary will be made for non-formulary medication use unless a Practitioner and/or Provider determines that use of the formulary drug may cause an adverse reaction to the Member or be contraindicated for the Member. To request an exception to the formulary, please call the Utilization Management Department toll-free at (888) 315-0885 | TTY/TDD: (877) 652-1844 (toll-free).
- **There are dispensing limitations.** One (1) Copayment Amount applies per Prescription Order or refill for a *1 - 34-day* supply, plus any applicable coinsurance amount(s). Two (2) Copayment Amounts apply per Prescription Order or refill for a *35 - 100-day* supply, plus any applicable coinsurance amount(s). Prescription Medications and nonprescription diabetes supplies are subject to a dispensing limit of a *100-day* supply.
- **Generic vs. Brand.** If a Generic Prescription Medication is the therapeutic equivalent of a Brand Name Prescription Medication, and is authorized by a Member's Professional Health Care Provider, benefits will be based on the Allowance for the Generic equivalent. If the Member does not accept the Generic equivalent, the Member is responsible for the cost difference between the Generic and the Brand Name Prescription Medication and applicable Cost Sharing Amounts.

Benefit Description

Covered medications and supplies

- Medications prescribed by a Provider of health services, including off-label use of medications, in accordance with federal and state laws and regulations
- Self-Administered Injectable Medications per Plan guidelines (available upon request). Please refer to your *Summary of Pharmacy*

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Benefits for a list of medications (injectable and high cost medications that must receive Preauthorization/Prior Approval, and must be obtained from CuraScript by calling (888) 773-7376 (toll-free)). If these medications are obtained from a retail pharmacy, or Practitioner and/or Provider's office, without Preauthorization/Prior Approval by Sanford Health Plan's Utilization Management Department, the Member may be responsible for the full cost of the medication.

- Diabetic medications (See Section 5(a) for Diabetic supplies, equipment, and self-management training benefits)

Not Covered:

- *Medications not listed in the Sanford Health Plan Formulary, without Preauthorization/Prior Approval, or a formulary exception from the Plan*
- *Replacement of a prescription drug due to loss, damage, or theft*
- *Outpatient medications dispensed in a Provider's office or non-retail pharmacy location*
- *Medications that may be received without charge under a federal, state, or local program*
- *Medications for cosmetic purposes, including baldness, removal of facial hair, and pigmenting or anti-pigmenting of the skin*
- *Refills of any prescription older than one (1) year*
- *Compound medications with no legend (prescription) medications*
- *Acne medication for Members over age thirty (30) (e.g. Retin-A, Microgel)*
- *B-12 injection (except for pernicious anemia)*
- *Drug Efficacy Study Implementation ("DESI") medications*
- *Experimental or Investigational medications*
- *Growth hormone, except when medically indicated and approved by The Plan*
- *Orthomolecular therapy, including nutrients, vitamins (including but not limited to prenatal vitamins without a written prescription),multi-vitamins with iron and/or fluoride, food supplements and baby formula (except to treat PKU or otherwise required to sustain life or amino acid-based elemental oral formulas), nutritional and electrolyte substances*
- *Medications, equipment or supplies available over-the-counter (OTC) (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*
- *Any medication that is equivalent to an OTC medication except for medications 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*
- *Anorexiants or weight management medications (except when Medically Necessary)*
- *Whole Blood and Blood Components Not Classified as Medications in the United States Pharmacopoeia*
- *Unit dose packaging*
- *Synthetic opioids (e.g. Methadone or Cyclazocine)*
- *All contraceptive medications, devices, appliances, supplies and related services when used for contraception, including contraceptive products that do not require a Prescription Order or dispensing by a Health Care Provider*
- *Prenatal vitamins unless 1) prescribed by a Health Care Practitioner and/or Provider; and 2) Member is enrolled in Healthy Pregnancy Program (see Section 5(a) for details)*

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Section 5(f) Dental benefits

IMPORTANT

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

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Insurance and are payable only when we determine they are Medically Necessary.

We cover Hospitalization for dental procedures only when a non-dental physical impairment exists which makes Hospitalization necessary to safeguard the health of the patient. See Section 5(b) for inpatient Hospital benefits. We do not cover the dental procedure unless it is described below.

Be sure to read Section 4, "How you get care", for valuable information about conditions for coverage.

YOU MUST GET PREAUTHORIZATION/PRIOR APPROVAL OF THESE SERVICES. See the benefits description below.

IMPORTANT

Benefit Description

NOTE: The following services require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

- Dental services provided by a Dentist (D.D.S.) in an office setting as a result of an accidental injury to the jaw, sound natural teeth, dentures, mouth or face.
  - Covered Services must be initiated within 12 months of the date of injury and completed within 24 months of the start of treatment or longer if a dental treatment plan approved by Sanford Health Plan is in place.
  - Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth
  - Associated radiology services are included
  - "Injury" does not include injuries to Natural Teeth caused by biting or chewing
- Diagnosis and treatment for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) and TMJ splints and adjustments if your primary diagnosis is TMJ/TMD
  - Splint limited to one (1) per Member per benefit period
- Coverage applies regardless of whether the services are provided in a Hospital or a dental office

NOTE: The following services require Preauthorization/Prior Approval; failure to get Preauthorization/Prior Approval may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 4.)

- Dental anesthesia for Members over age nine (9) and/or Members with a developmental disability, as determined by a licensed Practitioner and/or Provider, which places such a person at serious risk.

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

a. is a child under age nine (9);
b. is severely disabled or otherwise suffers from a developmental disability; or
c. has a high risk medical condition(s) as determined by a licensed Practitioner and/or Provider, which places such a person at serious risk.

Not Covered:

- *Natural teeth replacements including crowns, bridges, braces or implants*
- *Osseointegrated implant surgery (dental implants)*
- *Extraction of wisdom teeth*
- *Hospitalization for extraction of teeth if not otherwise specified as Covered in this Certificate of Insurance*
- *Dental x-rays or dental appliances*
- *Shortening of the mandible or maxillae for cosmetic purposes*
- *Services and supplies related to ridge augmentation, implantology, and preventive vestibuloplasty*
- *Dental appliances of any sort, including but not limited to bridges, braces, and retainers (except for appliances for treatment of TMJ/TMD)*

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Section 6. Limited and Non-Covered Services

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

General Exclusions

1. Health Care Services provided either before the effective date of the Member's coverage with the Plan or after the Member's coverage is terminated.
2. Health Care Services performed by any Provider who is the Member or a member of the Member's immediate family, including any person normally residing in the Member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only Participating Provider in the area, the Member may go to a Non-Participating Provider and receive In-Network coverage (Section 4). If the immediate family member is not the only Participating Provider in the area, the Member must go to another Participating Provider in order to receive coverage at the In-Network level.
3. Health Care Services Covered by Any Governmental Agency/Unit for military service-related injuries/diseases, unless applicable law requires the Plan to provide primary coverage for the same.
4. Health Care Services for injury or disease due to voluntary participation in a riot, unless source of injury is a result of domestic violence or a medical condition.
5. 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.
6. Health Care Services that the Plan determines are not Medically Necessary.
7. Experimental and Investigational Services.
8. Services that are not Health Care Services.
9. Complications from a non-covered procedure or service.
10. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner and/or Provider or electronic consultations
11. Services not performed in the most cost-efficient setting appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate.
12. Charges for professional sign language and foreign language interpreter services.
13. Charges for duplicating and obtaining medical records from *Non-Participating Providers* unless requested by the Plan.
14. Charges for sales tax, mailing, interest and delivery.
15. Charges for services determined to be duplicate services by the Plan's Chief Medical Officer or designee.
16. Charges that exceed the *Reasonable Costs* for Non-Participating Providers.
17. Services to assist in activities of daily living.
18. Alternative treatment therapies including, but not limited to: acupuncture, acupressure, biofeedback, chelation therapy, massage therapy unless covered per plan guidelines under Women's Health and Cancer Rights Act of 1998 (WHCRA) for mastectomy/lymphedema treatment, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, or therapeutic touch.
19. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management.
20. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics.
21. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home.
22. Any services or supplies for the treatment of obesity that do not meet the Plan's medical necessity 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.
23. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability.
24. Gender reassignment.
25. Sequela, which are primarily cosmetic that occur secondary to a weight loss procedure (e.g., Panniculectomy, breast reduction or reconstruction).
26. Incidental cholecystectomy performed at the time of weight loss surgery.
27. Cosmetic Services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance or psychological well-being or self-esteem, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services.
28. Food items for medical nutrition therapy (except as specifically allowed in the Covered Benefits Section of this Certificate of Insurance).
29. Any fraudulently billed charges or services received under fraudulent circumstances.
30. Genetic testing when performed in the absence of symptoms or high risk factors for a heritable disease; genetic testing when knowledge of genetic status will not affect treatment decisions, frequency of screening for the disease, or reproductive choices; genetic testing that has been performed in response to direct-to-consumer marketing and not under the direction of the Member's Practitioner and/or Provider.
31. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events. Participating Providers are not permitted to bill Members for services related to such events.
32. 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.
33. 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

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the responsibility of the Member.
34. Elective health services received outside of the United States.
35. Smoking deterrents.
36. All contraceptive medications, devices, appliances, supplies and related services when used for contraception, including contraceptive products that do not require a Prescription Order or dispensing by a Health Care Provider.
37. Abortions, except for those necessary to prevent the death of the woman. No benefits are available for removal of all or part of a multiple gestation.
38. Procedures to evaluate and reverse sterilization
39. Sleep studies performed at a facility not accredited by the American Academy of Sleep Medicine
40. Transplants and pre and post-transplant services at Non-Participating Center Of Excellence Facilities
41. Health Care Services ordered by a court or as a condition of parole or probation

Special situations affecting coverage

Neither the Plan, nor any Participating Provider, shall have any liability or obligation because of a delay or failure to provide services as a result of the following circumstances:

a. Complete or partial destruction of the Plan's facilities;
b. Declared or undeclared acts of War or Terrorism;
c. Riot;
d. Civil insurrection;
e. Major disaster or unforeseen natural events which materially interfere with the ability to provide Health Care Services;
f. Disability of a significant portion of the Participating Providers;
g. Epidemic or the inability to obtain vaccines or medications due to circumstances beyond the control of the Plan; or
h. A labor dispute not involving the Plan Participating Providers, the Plan will use its best efforts to arrange for the provision of Covered Services within the limitations of available facilities and personnel. If provision or approval of Covered Services under this Contract is delayed due to a labor dispute involving the Plan or Participating Providers, Non-Emergency Care may be deferred until after resolution of the labor dispute.

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

Services covered by other payors

The following are excluded from coverage:

1. Health services for which other coverage is either (1) required by federal, state or local 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 provided or payable under any Workers' Compensation or Occupational Disease Act or Law, are excluded from coverage by the Plan. However, if benefits are paid by the Plan and it is determined that the Member is eligible to receive Workers' Compensation for the same incident; the Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Member agrees to reimburse the Plan the full amount that the Plan has paid for Health Care Services when entering into a settlement or compromise agreement relating to compensation for Health Care Services covered by Workers' Compensation, or as part of any Workers' Compensation Award. The Plan reserves its right to recover against Member 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 Member or the Workers' Compensation carrier; or
   d. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.
   Member will not enter into a compromise or hold harmless agreement relating to any work related claims paid by the Plan, whether or not such claims are disputed by the Workers' Compensation insurer, without the express written agreement of the Plan.
2. Health Care Services received directly from Providers employed by or directly under contract with the Member's employer, mutual benefit association, labor union, trust, or any similar person or Group.
3. Health Care Services for injury or sickness for which there is other non-Group insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess, or contingent to the Plan. If the benefits subject to this provision are paid for or provided by the Plan, the Plan may exercise its Rights of Subrogation.
4. Health Care Services for conditions that under the laws of This State must be provided in a governmental institution.
5. Health Care Services covered by any governmental health benefit program such as Medicare, Medicaid, ESRD and TRICARE, unless applicable law requires the Plan to provide primary coverage for the same.

Services and payments that are the responsibility of the Member

1. Out-of-pocket costs, including Copays, Deductibles, and Coinsurance are the responsibility of the Member in accordance with the Summary of Benefits and Coverage and Summary of Pharmacy Benefits. Additionally, the Member is responsible to the Provider for payment for Non-Covered Services;
2. Finance charges, late fees, charges for missed appointments and other administrative charges; and
3. Services for which a Member is neither legally nor as customary practice required to pay in the absence of a Group health plan or other coverage arrangement.

Section 7. How Services Are Paid By the Plan

Reimbursement of Charges by Participating Providers

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

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

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

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

Reimbursement of Charges by Non-Participating Providers

Sanford Health Plan does not have contractual relationships with Non-Participating Practitioner and/or Providers and they may not accept the Plan's payment arrangements. In addition to any Copay, Deductible, or Coinsurance amount, which is required for that service, Members are responsible for any difference between the amount charged and the Plan's payment for covered services. Non-Participating Practitioner and/or Providers are reimbursed the Maximum Allowed Amount, which is the lesser of (a) the amount charged for a covered service or supply, or (b) Reasonable Costs.

You may need to file a claim when you receive services from Non-Participating Practitioner and/or Providers. Sometimes, Non-Participating Practitioners and/or Providers submit a claim to us 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 the Plan within one-hundred-eighty (180) days after the date that the cost was incurred. **If you, or the Non-Participating Practitioner and/or Provider, does not file the claim within one-hundred-eighty (180) days after the date that the cost was incurred, you may be responsible for payment of the claim.**

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

The Member must give the Plan written notice of the costs to be reimbursed. Claim forms are available from the Plan to aid in this process. Bills and receipts should be itemized, showing:

1. Covered Member's name and ID number;
2. Name and address of the Practitioner and/or Provider or Facility that provided the service or supply;
3. Dates Member received the services or supplies;
4. Diagnosis;
5. Type of each service or supply;
6. The charge for each service or supply;
7. A copy of the explanation of benefits, payments, or denial from any primary payer, such as the Medicare Summary Notice (MSN); and
8. Receipts/Member Costs, if you paid for your services.

Health Care Services Received 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 health care services if a Member travels to another country for the purpose of seeking medical treatment outside the United States.

Time Limits. Claims must be submitted to the Plan 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 may be responsible for payment of the claim.

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

Timeframe for Payment of Claims

The payment for reimbursement of the Member's costs will be made within *fifteen (15)* days of when the Plan receives a complete written claim with all required supporting information.

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

Member Bill Audit Program

Upon receiving notice of a claims payment, or Explanation of Benefits (EOB), from Sanford Health Plan, Members are encouraged to audit their medical bills and notify the Plan of any services which are improperly billed or of services that the Member did not receive.

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If, upon audit of a bill, an error of $40 or more is found, the Member will receive a minimum payment of $20 or 50% of the resulting savings for paid Covered Services up to a maximum payment of $500.

To obtain payment through the Member Bill Audit Program, the Member must complete a *Member Bill Audit Refund Request Form*. To obtain a form, log into your account at www.sanfordhealthplan.com or call Sanford Health Plan Member Services toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (toll-free) and request a form be mailed to you.

NOTE: This program does not apply when the NDPERS Benefit Plan is the secondary payor on a claim. For more information on claims with more than one payor, see Section 9, *Coordination of Benefits*.

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Section 8. Problem Resolution

Member Appeal Procedures

Sanford Health Plan makes decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. A Member, health care Practitioner and/or Provider with knowledge of the Member's medical condition, a Member's Authorized Representative, or an attorney have the right to file a complaint or an appeal of any Adverse Determination by Sanford Health Plan. The Member or his/her legal guardian may designate in writing to Sanford Health Plan an Authorized Representative to act on his/her behalf. This written designation of representation from the Member should accompany the request. For Expedited Appeals, a health care practitioner with knowledge of the Member's condition (e.g., treating practitioner) may act as the Member's authorized representative.

For members who request language services, Sanford Health Plan will provide service in the requested language through an interpreter or translated documents to help members register a complaint or appeal and to notify members about their complaint or appeal.

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-892-0675 (toll-free).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-0675 (toll-free).
Chinese (中文): 如果需要中文的帮助，请拨打这个号码1-800-892-0675 (toll-free).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-892-0675 (toll-free).

A TTY/TDD line is also available toll-free at (877) 652-1844 for members who are deaf, hard of hearing or speech-impaired.

Definitions

Adverse Determination: Means 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 a plan;
2. A determination that a benefit is not a Covered Benefit;
3. The imposition of a source-of-injury exclusion, 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 application or Certificate of Insurance and deny claims.

Appeal: Request to change a previous Adverse Determination made by Sanford Health Plan.

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

Complaint: An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and Practitioner and/or Provider Complaints. A process has been established for Members (or their designees) and Practitioners and/or Providers to use when they are dissatisfied with the Plan, 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 Member, applicant, or former Member or anyone acting on behalf of a Member, applicant, or former Member, who submits a Complaint. The Member and his/her legal guardian may designate in writing to Sanford Health Plan an Authorized Representative to act on his/her behalf. This written designation of representation from the Member should accompany the 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 that is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours. An Urgent care request means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination:

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

In determining whether a request is "Urgent," the Plan shall apply the judgment of a Prudent Layperson as defined in Section 10. A Practitioner, with knowledge of the Member's medical condition, who determines a request to be "Urgent" within the meaning of subdivisions (1) and (2) in this paragraph, shall have their request be treated as an Urgent Care Request.

Complaint Procedure

A Member has the right to file a Complaint either by telephone or in writing to the Plan. Member Services will make every effort to investigate and resolve all Complaints. Member Services can be reached at (800) 499-3416 (toll-free).

Oral Complaints: A complainant may orally submit a Complaint to the Plan. If the oral Complaint is not resolved to the complainant's satisfaction within *ten (10) business days* of receipt of the Complaint, the Plan will provide a Complaint form to the complainant, which must be completed and returned to the Plan for further consideration. Upon request, Member Services will provide assistance in submitting the Complaint form.

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Written Complaints: A complainant can seek further review of a Complaint not resolved by phone by submitting a written Complaint form. A Member, or his/her Authorized Representative may send the completed Complaint form, including comments, documents, records and other information relating to the Complaint, the reasons they believe they are entitled to benefits and any other supporting documents to: Sanford Health Plan, ATTN: NDPERS/Member Services, PO Box 91110, Sioux Falls, SD 57109.

Member Services will notify the complainant within *ten (10) business days* upon receipt of the Complaint form, 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.

Member Services will investigate and review the Complaint and notify the complainant of Sanford Health Plan's decision in accordance with the following timelines:

- 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 the Plan receives your request.
- In certain circumstances, the time period may be extended by up to fourteen (14) days upon agreement. In such cases, the Plan will notify the complainant in advance, of the reasons for the extension.

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.

If the complaint is not resolved to the Member's satisfaction, the Member, or his/her Authorized Representative, has the right to appeal any adverse determination made by Sanford Health Plan. Appeal Rights may be requested by calling the Plan at (800) 499-3416.

All notifications described above will comply with applicable law. A complete description of your Appeal Rights and the Appeal process will be included in your written response.

Types of Appeals

Types of appeals include:

- A **Prospective (Pre-Service) Appeal** is a request to change an Adverse Determination that the Plan must approve in whole or in part in advance of the Member obtaining care or services.
- A **Retrospective (Post-Service) Appeal** is a request to change an Adverse Determination for care or services already received by the Member.
- An **Expedited Appeal for Urgent Care** is a request to change a previous Adverse Determination made by Sanford Health Plan for an Urgent Care Request. If the Member's situation meets the definition of Urgent, their review will generally be conducted within 72 hours.

Continued Coverage for Concurrent Care

A Member 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.

Audit Trails

Audit trails for Complaints, Adverse Determinations and Appeals are provided by the Plan's Information System and an Access database which includes documentation of the Complaints, Adverse Determination and/or Appeals by date, service, procedure, substance of the Complaint/Appeal (including any clinical aspects/details, and reason for the Complaint, Adverse Determination and/or Appeal. The Appeal file includes telephone notification, and documentation indicating the date; the name of the person spoken to; the Member; the service, procedure, or admission authorization/approval; and the date of the service, procedure, or Adverse Determination and reason for determination. If the Plan indicates authorization/approval by use of a number, the number must be called the "authorization number."

Internal Appeal Procedure

Filing Deadline

Appeals can be made for up to 180 days from notification of the Adverse Determination.

Within *one-hundred-eighty (180) days* after the date of receipt of a notice of an Adverse Determination sent to a Member or the Member's Authorized Representative (as designated in writing by the Member), the Member or their Authorized Representative may file an Appeal with the Plan requesting a review of the Adverse Determination.

To Appeal, the Member may log into their account at www.sanfordhealthplan.com and complete the "Appeal Filing Form" under the *Forms* tab. The Member or their Authorized Representative may also contact the Plan by sending a written Appeal to the following address: Sanford Health Plan, ATTN: NDPERS, PO Box 91110, Sioux Falls, SD 57109-1110 or calling phone: (800) 499-3416 | TTY/TDD: 1-877-652-1844 (toll-free). If the Member, Authorized Representative, Practitioner/Provider, and/or attorney, has questions, they are encouraged to contact the Plan toll-free at (800) 499-3416 | TTY/TDD: 1-877-652-1844 (toll-free). Member Services is available to help with understanding information and processes. Alternate formats are also available and translation is available free of charge for written materials and Member communication with the Plan.

Appeal Rights

If the Member or their Authorized Representative (as designated in writing by the Member) files an Appeal for an Adverse Determination, the following Appeal Rights apply:

1. The Member shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. Members do not have the right to attend or have a representative attend the first level review.

2. The Member shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by, or at the direction of, Sanford Health Plan 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 Member a reasonable opportunity to respond prior to that date.
3. Before Sanford Health Plan can issue a final Adverse Determination based on a new or additional rationale, the Member must be provided, free of charge, with the rationale; the rationale must 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 Member a reasonable opportunity to respond prior to the date.
4. The Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Member's initial request.
5. The review shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
6. Full and thorough investigation of the substance of the Appeal, including any aspects of clinical care involved, will be coordinated by the Member Services Manager. The Plan will document the substance of the Appeal and any actions taken.
7. 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.
8. 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, the Plan shall consult with a health care professional 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.
9. The Plan shall identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Member's Adverse Determination, without regard to whether the advice was relied upon in making the benefit request determination.
10. 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.
11. The attending Practitioner and/or Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Appeal within three (3) business days of receipt of the Appeal. Sanford Health Plan will provide notice of any Adverse Determination in a manner consistent with applicable federal regulations.

For Prospective (Pre-service) Appeals: the Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within thirty (30) calendar days of receipt of the Appeal.

For Retrospective (Post-service) Appeals: the Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing or electronically within sixty (60) calendar days of receipt of the Appeal.

Expedited Internal Appeal Procedure

An **Expedited Appeal Procedure** is used when the condition presents as part of an Urgent Care Situation, as defined previously in this Certificate of Insurance.

An expedited review involving **Urgent Care Requests for Adverse Determinations of Pre-service or Concurrent** claims must be utilized if the Member or Practitioner and/or Provider acting on behalf of the Member believe that an expedited determination is warranted. All of the procedures of a standard review described apply. In addition, for an Expedited Appeal, the request for an expedited review may be submitted. This can be done orally or in writing and the Plan will accept all necessary information by telephone or electronically. In such situations, the Practitioner who made the initial Adverse Determination may review the appeal and overturn the previous decision.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the appeal via oral notification by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than within seventy-two (72) hours of receipt of the request. Sanford Health Plan will notify you orally by telephone or in writing by facsimile or via other expedient means. The Member and those Practitioners and/or Providers involved in the appeal will receive written notification within three (3) calendar days of the telephone notification. If your claim is no longer considered Urgent, it will be handled in the same manner as a Non-Urgent Pre-service or a Non-Urgent Post-Service Appeal, depending upon the circumstances.

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

Written Notification Process for Internal Appeals

The written notification from Sanford Health Plan for an Appeal of an Adverse Determination will include the following:

1. The results and date of the Appeal Determination;
2. The specific reason for the Adverse Determination in easily understandable language;
3. The titles and qualifications, including specialty, of the person or persons participating in the first level review process (Reviewer names are available upon request);
4. Reference to the evidence, benefit provision, guideline, and/or protocol used as the basis for the decision and notification that the Member on request can have a copy of the actual benefit provisions, guidelines, and protocols free of charge;
5. Notification the Member can receive, upon request and free of charge, reasonable access and copies of all documents, records and other

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information relevant to the Member's benefit request;
6. Statement of the reviewer's understanding of the Member's Appeal;
7. The Reviewer's decision in clear terms and The Contract basis or medical rationale in sufficient detail for the Member to respond further;
8. If the Adverse Determination is based on medical necessity, notification and instructions on how the Practitioner and/or Provider can contact the Practitioner and/or Provider or appropriate specialist to discuss the determination;
9. 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 Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
10. If applicable, instructions for requesting:
    a. 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)** Review, a statement indicating:
    a. The written procedures governing the voluntary review, including any required timeframe for the review; and
    b. The Member's right to bring a civil action in a court of competent jurisdiction;
12. Notice of the Member's right to contact the North Dakota Insurance Commissioner for assistance at any time at:
    North Dakota Insurance Department — Email: insurance@nd.gov
    600 E. Boulevard Ave. — Consumer hotline: (800) 247-0560 (toll-free)
    Bismarck, ND 58505-0320 — TTY: (800) 366-6888 (toll-free)
13. Notice of the right to initiate the External Review process for Adverse Determinations based on medical necessity. Refer to "Independent, External Review of Final Determinations" in this Section for details on this process. Final Adverse Determination letters will contain information on the circumstances under which Appeals are eligible for External Review and information on how the Member can seek further information about these rights.
14. If the Adverse Determination is completely overturned, the decision notice must state the decision and the date.

Independent, External Review of Final Determinations (Denials)

External Review Requests

Members may file a request for External Review with the Plan or with the North Dakota Insurance Commissioner at:
North Dakota Insurance Department — Email: insurance@nd.gov
600 E. Boulevard Ave. — Consumer hotline: (800) 247-0560 (toll-free)
Bismarck, ND 58505-0320 — TTY: (800) 366-6888 (toll-free)

For independent, External Review of a final Adverse Determination, the Plan will provide:

1. Members the right to an independent, third party, binding review whenever they meet ALL of the following eligibility criteria:
    a. The Member is Appealing an Adverse Determination that is based on medical necessity (benefits Adverse Determinations are not eligible); and
    b. The Member has exhausted Sanford Health Plan's internal Appeal process and the Plan's decision is unfavorable to the Member; and
    c. The request for independent, External Review is filed within four (4) months of the date that the Plan's final Adverse Determination was made.
2. Notification to Members about the independent, External Appeal program and decision are as follows:
    a. General communications to Members, at least annually, to announce the availability of the right to independent, External Review.
    b. Letters informing Members and Practitioners of the upholding of an Adverse Determination covered by this standard including notice of the independent, External Appeal rights, directions on how to use the process, contact information for the independent, External Review organization, and a statement that the Member does not bear any costs of the independent, External Review organization, unless the independent external reviewer upholds the denial of a claim, then the Member is responsible to pay all costs associated with the external review.
    c. The External Review organization will communicate its decision in clear terms in writing to the Member and the Plan. The decision will include:
        i. a general description of the reason for the request for external review;
        ii. the date the independent review organization received the assignment from the Plan to conduct the external review;
        iii. the date the external review was conducted;
        iv. the date of its decision;
        v. the date the external review was conducted;
        vi. the date of its decision;
        vii. the principal reason(s) for the decision, including any, medical necessity rationale or evidence-based standards that were a basis for its decision; and
        viii. the list of titles and qualifications, including specialty, of individuals participating in the appeal review; a statement that the reviewer understands the pertinent facts of the appeal, with references to the evidence or documentation that was used as a basis for the decision.
    d. The External Review organization must also notify the Member how and when Members receive any payment or service in the case of overturned Adverse Determinations.
3. Conduct of the External Appeal Review program is as follows:
    a. Within five (5) business days following the date of receipt of the external review request, the Plan shall complete a preliminary review of the request to determine whether:

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i. The Member is or was a covered person in the health benefit 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;

ii. The health care service that is the subject of the Adverse Determination is a covered service under the Member's health benefit plan, but for a determination by the health carrier 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;

iii. The Member has exhausted the Plan's internal Appeal process; and

iv. The Member has provided all the information and forms required to process an external review.

b. Within one (1) business day after completion of the preliminary review, the North Dakota Insurance Department (NDID) shall notify the Member and, if applicable, the Member's authorized representative in writing whether the request is complete and eligible for external review.

i. If the request is not complete, the NDID shall inform the Member and, if applicable, the Member's authorized representative in writing and include in the notice what information or materials are needed to make the request complete; or if the request is not eligible for external review, the NDID shall inform the Member and, if applicable, the Member's authorized representative in writing and include the reasons for its ineligibility. If the Independent Review Organization upheld the denial, there is no further review available under this appeals process. However, you may have other remedies available under State or Federal law, such as filing a lawsuit.

ii. If the request is complete, within one (1) business day after verifying eligibility, the NDID shall assign an independent review organization and notify in writing the Member, and, if applicable, the Member's authorized representative of the request's eligibility and acceptance for external review. The Member may submit in writing to the assigned Independent Review Organization within five (5) business days following the date of receipt of the notice provided by the NDID any additional information that the independent review organization shall consider when conducting the external review. The independent review organization is not required to, but may, accept and consider additional information submitted after ten (10) business days.

iii. Within five (5) business days after the date the NDID determines the request is eligible for external review, of receipt, the NDID shall provide to the assigned independent review organization the documents and any information considered in making the adverse determination or final adverse determination. For Grandfathered Plans, External reviews are conducted by the North Dakota Health Care Review, Inc., another peer review organization meeting the requirements of §1152 of the Social Security Act, or any person designated by the Insurance Commissioner.

c. The North Dakota Insurance Department contracts with the independent, external review organization that:

i. is accredited by a nationally recognized private accrediting entity;

ii. conducts a thorough review in which it considers all previously determined facts, allows the introduction of new information, considers and assesses sound medical evidence, and makes a decision that is not bound by the decisions or conclusions of the Plan or determinations made in any prior appeal.

iii. has no material professional, familial or financial conflict of interest with Sanford Health Plan.

d. With the exception of exercising its rights as party to the appeal, Sanford Health Plan must not attempt to interfere with the Independent Review Organization's proceeding or appeal decision.

e. Sanford Health Plan will provide the Independent Review Organization with all relevant medical records as permitted by state law, supporting documentation used to render the decision pertaining to the Member's case (summary description of applicable issues including the Plan's decision, criteria used and clinical reasons, utilization management criteria, communication from the Member to the Plan regarding the appeal), and any new information related to the case that has become available since the internal appeal decision.

f. The Member is not required to bear costs of the Independent Review Organization's review, including any filing fees unless the independent external reviewer upholds the denial of a claim, then the Member is responsible to pay all costs associated with the external review.

g. The Member or his/her legal guardian may designate in writing a representative to act on his/her behalf. A Practitioner and/or Provider may not file an Appeal without explicit, written designation by the Member.

h. The Independent Review Organization's decision is final and binding to the Plan and the Plan implements the Independent Review Organization's decision within the timeframe specified by the Independent Review Organization. The decision is not binding to the Member, because the Member has legal rights to pursue further appeals in court if they are dissatisfied with the outcome. However, a Member may not file a subsequent request for external review involving the same adverse determination for which the Member has already received an external review decision.

4. Sanford Health Plan maintains and tracks data on each appeal case, including descriptions of the denied item(s), reasons for denial, Independent, External Review organization decisions and reasons for decisions. Sanford Health Plan uses this information in tracking and evaluating its medical necessity decision-making process and improving the quality of its clinical decision making procedures. This information is reported to the Medical Management Quality Committee when a case is resolved for discussion and plan of care or action.

Expedited External Review Requests

1. A Member or the Member's authorized representative may request an expedited external review of a final Adverse Determination if the Plan's Adverse Determination involves either an Urgent Care Request for Prospective (pre-service) or a Concurrent Review Request for which:

a. the timeframe for completion of a standard internal review would seriously jeopardize the life or health of the Member; or would jeopardize the Member's ability to regain maximum function; or

b. in the case of a request for Experimental or Investigational services, the treating Provider certifies, in writing, that the requested health care services or treatment would be significantly less effective if not promptly initiated; and

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c. The Member has exhausted Sanford Health Plan's internal Appeal process and the Plan's decision is unfavorable to the Member.

2. The Member has the right to contact the North Dakota Insurance Commissioner for assistance at any time at:
   North Dakota Insurance Department
   600 E. Boulevard Ave.
   Bismarck, ND 58505-0320
   Email: insurance@nd.gov
   Consumer hotline: (800) 247-0560 (toll-free)
   TTY: (800) 366-6888 (toll-free)
3. An expedited external review is not provided for Retrospective Adverse Determinations.
4. Immediately upon receipt of the request from the Member or the Member's Representative, the NDID 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, the NDID will give notification to the Member or the Member's Representative that they may appeal to the state insurance department.
5. Upon determination that the Expedited External Review request meets the reviewability requirements, the NDID 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 the Plan's utilization review or internal appeal process.
6. The Plan 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.
7. The independent review organization will make a decision to uphold or reverse the adverse determination and provide oral notification to the Member, and, if applicable, the Member's authorized representative, and the treating Practitioners and/or Providers as expeditiously as the Member'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 Member and those Practitioners and/or Providers involved in the appeal will receive written notification within *forty-eight (48)* hours of the oral notification.
8. Upon the Plan's receipt of the independent review organization's decision to reverse the adverse determination, the Plan shall immediately approve the coverage that was the subject of the adverse determination.
9. If the independent external reviewer upholds the denial of a claim, the Member is responsible to pay all costs associated with the external review.

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Section 9. Coordination of Benefits

Sanford Health Plan follows North Dakota Administrative Code §45-08-01.2-03 regarding Coordination of Benefits (COB). The COB provision applies when a person has health care coverage under more than one "Plan" as defined for COB purposes.

Applicability

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

Definitions (for COB Purposes Only)

A. **A Plan** is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for Members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

1. Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel Plans or other forms of group or group type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under group or individual automobile contracts; and Medicare or any other federal governmental Plan, as permitted by law.
2. Plan does not include: Hospital indemnity coverage or other fixed indemnity coverage; accident-only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident-type coverage; benefits for nonmedical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental Plans, unless permitted by law.

Each contract for coverage under Section A. (1) or (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. **This Plan** means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits of other Plans. Any other part of the contract providing health care benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

C. **The order of benefit determination rules determine whether this Plan is a primary Plan or secondary Plan when the person has health care coverage under more than one Plan**. When this Plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When this Plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that total Plan benefits do not exceed 100% of the total Allowable Expense.

D. **Allowable Expense** is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by any Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable Expense. The following are examples of expenses that are not Allowable Expenses:

1. The difference between the cost of a semiprivate Hospital room and a private Hospital room is not an Allowable Expense, unless one of the Plans provides coverage for private Hospital room expenses.
2. If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable Expense.
3. If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.
4. If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's payment arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the secondary Plan to determine its benefits.
5. The amount of any benefit reduction by the primary Plan because a covered person has failed to comply with the Plan provisions is not an Allowable Expense. Examples of these types of Plan provisions include second surgical opinions, Preauthorization/Prior Approval of admissions, and preferred provider arrangements.

E. **Closed Panel Plan** is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel of Providers contracted with or employed by the Plan, and that excludes coverage for services provided by other Providers, except in cases of Emergency or referral by a panel member.

F. **Custodial Parent** is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one-half of the calendar year excluding any temporary visitation.

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Order of Benefit Determination Rules

When a person is covered by two or more Plans, the rules for determining the order of benefits payments are as follows:

A. The primary Plan pays or provides its benefits according to its terms of coverage and without regard to the benefits of any other Plan.

B. (1) Except as provided in paragraph 2.(a) below, Plan that does not contain a coordination of benefits provision that is consistent with this regulation is always primary unless the provisions of both Plans state that the complying Plan is primary.
(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base Plan Hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel Plan to provide out-of-network benefits.

C. A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

D. Each Plan determines its order of benefits using the first of the following rules that apply:

1. Nondependent or dependent. The plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber, or retiree, is the primary plan and the plan that covers the person as a dependent is the secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a Dependent (e.g., a retired employee); then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, policyholder, subscriber, or retiree is the secondary plan and the other plan is the primary plan.
2. Dependent child covered under more than one plan. Unless there is a court decree stating otherwise, when a Dependent child is covered by more than one Plan the order of benefits is determined as follows:
   (a) For a Dependent child whose parents are married or are living together, whether or not they have ever been married:
      i. the plan of the parent whose birthday falls earlier in the calendar year is the primary plan; or
      ii. if both parents have the same birthday, the plan that has covered the parent the longest is the primary plan.
   (b) For a Dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:
      i. If a court decree states that one of the parents is responsible for the Dependent 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 plan years commencing after the plan is given notice of the court decree;
      ii. If a court decree states that both parents are responsible for the Dependent child's health care expenses or health care coverage, the provisions of subparagraph a above shall determine the order of benefits;
      iii. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the Dependent child, the provisions of subparagraph a above shall determine the order of benefits; or
      iv. If there is no court decree allocating responsibility for the Dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:
         (1) The Plan covering the Custodial Parent;
         (2) The Plan covering the Spouse of the Custodial Parent;
         (3) The Plan covering the non-Custodial Parent; and then
         (4) The Plan covering the Spouse of the non-Custodial Parent.
   (c) For a Dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.
3. Active employee or retired or laid-off employee. The Plan that covers a person is an active employee, that is, an employee who is neither laid off nor retired, is the primary Plan. The Plan covering that same person as a retired or laid-off employee is the secondary Plan. The same would hold true if a person is a Dependent of an active employee and that same person is a Dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.(1) can determine the order of benefits.
4. COBRA or state continuation coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the person as an employee, Member, subscriber, or retiree or covering the person as a Dependent of an employee, Member, subscriber, or retiree is the primary Plan and the COBRA or state or other federal continuation coverage is the secondary Plan. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled D.(1) can determine the order of benefits.
5. Longer or shorter length of coverage. The Plan that covered the person as an employee, Member, policyholder, subscriber, or retiree longer is the primary Plan and the Plan that covered the person the shorter period of time is the secondary Plan.
6. If the preceding rules do not determine the order of benefits, that Allowable Expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

Effect of COB on the Benefits of this Plan

A. When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a Plan year are not more than the total Allowable Expenses. In determining the amount to be paid for any claim, the secondary Plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the primary Plan. The secondary Plan may then reduce its payment by the amount so that, when

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combined with the amount paid by the primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, the secondary Plan shall credit to its Plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

B. If a covered person is enrolled in two or more closed panel plans, and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one closed panel plan; COB shall not apply between that plan and other closed panel plans.

Right to Receive and Release Needed Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. Sanford Health Plan may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits. Sanford Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Sanford Health Plan any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

A payment made under another Plan may include an amount that should have been paid under this Plan. If it does, Sanford Health Plan may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under this Plan. Sanford Health Plan will not have to pay that amount again. The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Right of Recovery

If the amount of the payments made by Sanford Health Plan is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Coordination of Benefits with Medicare

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

If a Practitioner and/or Provider has accepted assignment of Medicare, the Plan pays the difference between what Medicare pays and the Plan's Allowable Expense.

Members with End Stage Renal Disease (ESRD)

1. The Plan has primary responsibility for the claims of a Member:
   a. Who is eligible for Medicare secondary benefits because of ESRD, and;
   b. During the Medicare coordination period of 30 months, which begins with the earlier of:
      i. the month in which a regular course of renal dialysis is initiated, or
      ii. in the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.
2. The Plan has secondary responsibility for the claims of a Member:
   a. Who is eligible for Medicare primary benefits because of ESRD, and the Medicare coordination period of thirty (30) months has expired; or
   b. Who is eligible for Medicare on the basis of age or disability when the Member becomes eligible on the basis of ESRD, and certain other conditions are met.

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Section 10. Definitions of terms we use in this Certificate of Insurance

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 Member is discharged or released from the facility and is no longer registered as a patient. Also known as Hospitalization.
Allowance or Allowed Charge	The maximum dollar amount that payment for a procedure or service is based on as determined by Sanford Health Plan.
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.
Annual Enrollment	A period of time at least once a year when Eligible Group Members may enroll themselves and their Dependents in the Plan. Annual Enrollment does not pertain to non-Medicare retirees.
Authorized Representative	A person to whom a covered person has given express written consent to represent the Member, a person authorized by law to provide substituted consent for a Member, a family member of the Member or the Member's treating health care professional if the Member is unable to provide consent, or a health care professional if the Member's Plan requires that a request for a benefit under the plan be initiated by the health care professional. For any Urgent Care Request, the term includes a health care professional with knowledge of the Member's medical condition.
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 Members for services related to Avoidable Hospital Conditions.
Basic Plan	The Member elects to access the health care system through a Health Care Provider that is not a part of the Preferred Provider Organization. Benefit payment will be at the Basic Plan level. Health Care Providers accessed at the Basic Plan level are also Participating Providers.
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.
Benefit Plan	The agreement with Sanford Health Plan, including the Subscriber's membership application, Identification Card, the Benefit Plan Agreement, this Certificate of Insurance, the Benefit Plan Attachment and any supplements, endorsements, attachments, addenda or amendments
[The] Board	Means the North Dakota Public Employees Retirement System (NDPERS) board.
Calendar Year	A period of one year which starts on January 1st and ends December 31st.
Case Management	A coordinated set of activities conducted for individual patient management of chronic, serious, complicated, protracted, or other health conditions.
Claims Administrator or Claims Payor	Sanford Health Plan
Class of Coverage	The type of coverage the Subscriber is enrolled under, identifying who is eligible to receive benefits for Covered Services under this Benefit Plan. Classes of Coverage under this Benefit Plan are Single Coverage and Family Coverage.
Coinsurance Amount	A percentage of the Allowed Charge for Covered Services that is a Member's responsibility.
Coinsurance Maximum Amount	The total Coinsurance Amount that is a Member's responsibility during a Benefit Period. The Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period
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 received at a Residential Treatment Facility and ongoing outpatient services, including ongoing ambulatory care.
[This] Contract or [The] Contract	This Certificate of Insurance, which is a statement of the essential features and services given to the Subscriber by the Plan, including all attachments, the Group's application, the applications of the Subscribers and the Health Maintenance Contract.

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Copayment (Copay)	A specified dollar amount payable by the Member for certain Covered Services. Health Care Providers may request payment of the Copayment Amount at the time of service.
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 doesn't 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 Member is entitled under the terms of This Contract.
Creditable Coverage	Benefits or coverage provided under: a. A group health benefit plan (as such term is defined under North Dakota law); b. A health benefit plan (as such term is defined under North Dakota law); c. Medicare; d. Medicaid; e. Civilian health and medical program for uniformed services; f. A health plan offered under 5 U.S.C. 89; g. A medical care program of the Indian Health Service or of a tribal organization; h. A state health benefits risk pool, including coverage issued under N.D.C.C. Chapter 26.1-08; i. 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; j. A health benefit plan under section 5(e) of the Peace Corps Act [Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e)]; and k. 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 Amount	A specified dollar amount payable by the Member for certain Covered Services received during the Benefit Period.
Dependent	The Spouse and any Dependent Child of a Subscriber.
Dependent Child	The definition of a Dependent Child of a Subscriber includes a child who is related to the Subscriber as a natural child, a child placed for adoption, a legally adopted child, a child for whom the Subscriber has legal guardianship, a stepchild, or a foster child; and is one of the following: (a) under the age of twenty-six (26), (b) incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Policyholder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within thirty-one (31) days of the Plan's request; or (c) the Subscriber's grandchild(ren) or those of the Subscriber's living, covered Spouse, who legally reside with the Policyholder/Subscriber and (1) the parent of the grandchild(ren) is an Covered Dependent also covered by this Plan; and (2) both the Dependent and child of such Dependent (grandchild) are chiefly dependent upon the Policyholder/Subscriber for support. Dependent coverage does not include the spouse of an adult Dependent child.
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 24-hour Facility or nursing care.
Eligible Dependent	An Eligible Dependent includes: (1) The Spouse of the Subscriber; and (2) A Dependent child who is related to the Subscriber as a natural child, a child placed for adoption, a legally adopted child, a child for whom the Subscriber has legal guardianship, a stepchild, or a foster child; and is one of the following: (a) under the age of twenty-six (26), (b) incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Policyholder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child's disability within thirty-one (31) days of the Plan's request; or (c) the Subscriber's grandchild(ren) or those of the Subscriber's living, covered Spouse, who legally reside with the Policyholder/Subscriber and (1) the parent of the grandchild(ren) is an Covered Dependent also covered by this Plan; and (2) both the Dependent and child of such Dependent (grandchild) are chiefly dependent upon the Policyholder/Subscriber for support. Eligible Dependents do not include the spouse of an adult Dependent child.
Eligible Group Member	Any Group Member who meets the specific eligibility requirements of NDPERS.

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Emergency Care Services	Emergency Care Services means: (1) Within the Service Area: covered health care services rendered by Participating or Non-participating Providers under unforeseen conditions that require immediate medical attention. Emergency care services within the Service Area include covered health care services from Non-participating Providers only when delay in receiving care from Participating Providers could reasonably be expected to cause severe jeopardy to the Member's condition or (2) Outside the Service Area: medically necessary health care services that are immediately required because of unforeseen illness or injury while the enrollee is outside the geographical limits of the Plan's Service Area.
Emergency Medical Condition	A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any 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.
Enrollee	An individual who is covered by This Plan.
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 must be utilized if the Member, or Practitioner and/or Provider acting on behalf of the Member, believes that an expedited determination is warranted.
Experimental or Investigational Services	Health Care Services where the Health Care Service in question either: a. is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or b. requires approval by any governmental authority and such approval 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.
Family Coverage	The Class Of Coverage identifying that the Subscriber and Eligible Dependents are enrolled to received benefits for Covered Services under this Plan.
Formulary	A list of prescription medication products, which are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modifications. Additional medications may be added or removed from the Formulary throughout the year.
Gestational Carrier	An adult woman who enters into an agreement to have a fertilized egg, gamete, zygote or embryo implanted in her and bear the resulting child for intended parents, where the embryo is conceived by using the egg and sperm of the intended parents.
Grievance	A written complaint submitted in accordance with the Plan's formal grievance procedure by or on behalf of the enrollee regarding any aspect of the Plan relative to the Member.
[The] Group or [This] Group	NDPERS has signed an agreement with Sanford Health Plan to provide health care benefits for its eligible employees, retirees, and Eligible Dependents.
Group Contract Holder	The individual to whom a [Group] Contract has been issued.
Group Member	Any employee, sole proprietor, partner, director, officer or Member of the Group.
Health Care Services	Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease.
Hospital	A 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. Benefits may not be restricted in a way that is based upon the number of hours that the Member stays in the Hospital.
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.

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Infertility Services Deductible Amount	A specified dollar amount payable by the Member during their lifetime for infertility services. The Infertility Services Deductible Amount does not apply toward the Out-of-Pocket Maximum Amount.
In-Network Benefit Level	The PPO Plan level of benefits provided when a Member seeks services from a Participating Practitioner and/or Provider.
Intensive Outpatient Program (IOP)	Provides mental health and/or substance use disorder outpatient treatment services during which a Member 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	Intermediate Care means care in a Facility, corporation or association licensed or regulated by the State for the accommodation of persons, who, because of incapacitating infirmities, require minimum but continuous care but 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.
Maintenance Care	Treatment provided to a Member whose condition/progress has ceased improvement or could reasonably be expected to be managed without the skills of a Health Care Provider. Exception: periodic reassessments are not considered Maintenance Care
Maximum Allowed Amount	The amount established by Sanford Health Plan using various methodologies for covered services and supplies. Sanford Health Plan's Maximum Allowable Amount is the lesser of (a) the amount charged for a covered service or supply; or (b) Reasonable Costs.
Medically Necessary or Medical Necessity	Health Care Services that are appropriate and necessary as determined by any Participating Provider, in terms or type, frequency, level, setting, and duration, according to the Member'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 the Plan, as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and a. help restore or maintain the Members health; or b. prevent deterioration of the Member's condition; or c. prevent the reasonably likely onset of a health problem or detect an incipient problem; or d. not considered Experimental or Investigative
Member	The Subscriber and, if another Class of Coverage is in force, the Subscriber's Eligible Dependents
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	Teeth, which are whole and without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury.
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 Members for services related to Never Events.
NDPERS	The North Dakota Public Employees Retirement System.
Non-Covered Services	Those Health Care Services to which a Member is not entitled and are not part of the benefits paid under the terms of This Contract.
Non-Participating Provider	A Provider that has not signed a contract with the Plan.
Non-Payable Health Care Provider	A Health Care Provider that is not reimbursable by the Plan. 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 Member's immediate family.
Out-of-Network Benefit Level	The Basic Plan level of benefits provided when a Member seeks services from a Non-PPO Practitioner and/or Provider. This is most often referred to as benefits received under the Basic Plan level but may include services received from Practitioners and/or Providers that have not signed a contract with the Plan.

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Out-of-Pocket Maximum Amount	The total Deductible and Coinsurance Amounts for certain Covered Services that are a Member'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, less Copayment Amounts incurred during the remainder of the Benefit Period. The Out-of-Pocket Maximum Amount renews on January 1 of each consecutive Benefit Period. Medical and prescription drug Copayment amounts do not apply toward the Out-of-Pocket Maximum Amount.
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.
Participating [Health Care] Provider	A Provider who, under a contract with the Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Members with an expectation of receiving payment, other than Coinsurance, Copays, or Deductibles, directly or indirectly, from the Plan. A Participating Provider includes Health Care Providers at either the Basic or PPO Plan level.
Physician	An individual licensed to practice medicine or osteopathy.
[The] Plan or [This] Plan	Sanford Health Plan.
Plan Administrator	North Dakota Public Employees Retirement System (NDPERS)
PPO (Preferred Provider Organization) Plan	A group of Health Care Providers who provide discounted services to the Members of NDPERS. Because PPO Health Care Providers charge Sanford Health Plan less for medical care services provided to the Members of NDPERS, cost savings are passed on to Members by way of reduced Cost Sharing Amounts. To receive a higher payment level, Covered Services must be received from an NDPERS PPO Health Care Provider. Health Care Providers accessed at the PPO level are also Participating Providers.
Practitioner	A professional who provides health care services. Practitioners are usually required to be licensed as required by law. Practitioners are also Physicians.
Preauthorization	The process of the Member or the Member's representative notifying Sanford Health Plan to request approval for specified services. Eligibility for benefits for services requiring Preauthorization is contingent upon compliance with the provisions in Sections 2, 4 and 5. Preauthorization does not guarantee payment of benefits.
Prescription Drug Coinsurance Maximum Amount	The total Formulary Coinsurance Amount for Prescription Medications that is a Member's responsibility during a Benefit Period. When this Coinsurance Maximum Amount is met, this Benefit Plan will pay 100% of the Allowed Charge for Formulary Prescription Medications, less Copayment Amounts incurred during the remainder of the Benefit Period. This Coinsurance Maximum Amount renews on January 1 of each consecutive Benefit Period. Copayment Amounts do not apply toward this Coinsurance Maximum Amount.
Preventive	Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan.
Primary Care 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 Member.
Prior Approval	The process of the Member or Member's representative providing information to Sanford Health Plan substantiating medical necessity of services in order to receive benefits for the requested service. Sanford Health Plan reserves the right to deny or pay benefits at the Basic Plan level if Prior Approval is not obtained.
Prospective (Pre-service) Review	Means Urgent and non-Urgent Utilization Review conducted prior to an admission or the provision of a Health Care Service or a course of treatment. Also referred to as Preauthorization/Prior Approval.
[Health Care] Provider	An individual, institution or organization that provides services for Members. Examples of Providers include but are not limited to Hospitals, Physicians, Practitioners, 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.
Reasonable Costs	Those costs that do not exceed the lesser of (a) negotiated schedules of payment developed by the Plan, which are accepted by Participating Practitioners and/or Providers; or (b) the prevailing marketplace charges.

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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 Sanford Health Plan 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 Member 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 Members or the Plan for services related to Serious Reportable Events.
[NDPERS] Service Agreement and/or [Group] Contract	The Service Agreement between NDPERS and Sanford Health Plan that is a contract for Health Care Services, which by its terms limits eligibility to enrollees of a specified group. The Group Contract may include coverage for Dependents.
Service Area	The geographic Service Area of the Plan approved by the State's Insurance Department.
Single Coverage	The Class of Coverage identifying that only the Subscriber is enrolled to received benefits for Covered Services under this Plan.
Skilled Nursing Facility	A Facility that is operated pursuant to the presiding state law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly-licensed Physician.
Spouse	The Subscriber's Spouse under a legally existing marriage between persons of the opposite sex
[This] State or [The] State	The State of North Dakota.
Subscriber	An Eligible Group Member who is enrolled in the Plan whose employment or other status (except family dependency) is the basis for eligibility for enrollment in the Plan. A Subscriber is also a Member and Enrollee.
Surrogate	An adult woman who enters into an agreement to bear a child conceived through assisted conception for intended parents.
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 Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or 2. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
Urgent Care Situation	An Urgent Care Situation is a degree of illness or injury, which is less severe than an Emergency Condition, but requires prompt medical attention within *twenty-four (24)* hours, such as stitches for a cut finger. Urgent care means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination: a. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a Prudent Layperson's judgment; or b. In the opinion of a Practitioner and/or Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request.
Us/We/Our	Refers to Sanford Health Plan
Utilization Review	A set of formal techniques used by the Plan to monitor and evaluate the medical necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Prospective (pre-service) Review, second opinion, Preauthorization/Prior Approval, Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review.

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Section 11. When Coverage Ends

Termination of Member Coverage

For the purposes of this Benefit Plan, upon termination of Member Coverage, the following provisions control:

1. **Determining Ineligibility.** Eligibility for benefits subsequent to retirement or termination will be determined pursuant to N.D.C.C. §54-52.1-03.
2. **Continuation of health, dental, vision, or prescription drug coverage after termination.** An employee who terminates employment and is not receiving a monthly retirement benefit from one of the eligible retirement systems, and applies for continued coverage with the health, dental, vision, or prescription drug plan may continue such coverage for a maximum of eighteen (18) months by remitting timely payments to the Board. The employee desiring coverage shall notify the Board within sixty (60) days of the termination. Coverage will become effective on the first day of the month following the last day of coverage by the employing agency, if an application is submitted within sixty (60) days. An individual who fails to timely notify the board is not eligible for coverage. [N.D.A.C. §71-03-03-06]
3. **Continuation of health, dental, vision, or prescription drug coverage for dependents.** Dependents of employees with family coverage may continue coverage with the group after their eligibility would ordinarily cease. This provision includes divorced or widowed spouses and children when they are no longer dependent on the employee. Coverage is contingent on the prompt payment of the premium, and in no case will coverage continue for more than thirty-six (36) months. Dependents desiring coverage shall notify the board within sixty (60) days of the qualifying event and must submit an application in a timely manner. An individual who fails to notify the Board within the sixty (60) days, and who desires subsequent coverage, will not be eligible for coverage. [N.D.A.C. §71-03-03-07]
4. **Leave without pay.** An employee on an approved leave without pay may elect to continue coverage for the periods specified in the plans for life insurance, health, dental, vision, or prescription drug coverages by paying the full premium to the agency. An eligible employee electing not to continue coverage during a leave of absence is entitled to renew coverage for the first of the month following the month that the employee has returned to work if the employee submits an application for coverage within the first thirty-one (31) days of returning to work. An eligible employee failing to submit an application for coverage within the first thirty-one (31) days of returning to work or eligibility for a special enrollment period, may enroll during the annual open enrollment and may be subject to a six-month waiting period for preexisting conditions. Upon a showing of good cause, the executive director may waive the thirty-one day application requirement. [N.D.A.C. §71-03-03-09]
   a. In the event an enrolled eligible employee is not entitled to receive salary, wages, or other compensation for a particular calendar month, that employee may make direct payment of the required premium to the board to continue the employee's coverage, and the employing department, board, or agency shall provide for the giving of a timely notice to the employee of that person's right to make such payment at the time the right arises. [N.D.C.C. §54-52.1-06]

NOTE: A Member's coverage may not be terminated due to the status of the Member's health or because the Member has exercised his or her rights under the Plan's Policy on Member Complaints or the Policy on Appeal Procedures for Medical Review Determinations. For details on Complaints and Appeals, see Section 8 of this COI.

Continuation

1. If the Subscriber becomes ineligible for group membership under this Benefit Plan due to an inability to meet NDPERS requirements and enrollment regulations, coverage will be canceled at the end of the last month that premium was received from the Plan Administrator. Exceptions may be made if:
   a. The Plan Administrator cancels coverage. Conversion coverage will not be offered to a Subscriber, if on the date of conversion the Plan Administrator, through which the Subscriber is eligible, has terminated coverage with Sanford Health Plan, and the Plan Administrator has enrolled with another insurance carrier.
   b. The Plan Administrator no longer meets Sanford Health Plan's group coverage requirements. The Subscriber will be given the right to convert to a nongroup benefit plan, subject to premiums and benefit plan provisions in effect, if application for such coverage is made within 31 days after the termination date of the previous benefit plan.
   c. Ineligibility occurs because the Subscriber elects to discontinue employment, is terminated or is otherwise no longer covered under the group health plan. The Subscriber may elect continuation coverage through the Plan Administrator in accordance with state and federal law.
   d. Ineligibility occurs because the Subscriber is no longer eligible to continue coverage under the group (NDPERS). The Subscriber may elect conversion (individual) coverage on a nongroup basis, subject to premiums and benefit plan provisions for nongroup coverage then in effect, if the Subscriber applies for nongroup coverage within 31 days after the termination date of the previous group health plan coverage.
2. If a Member becomes otherwise ineligible for group membership under this Benefit Plan, Sanford Health Plan must at least offer the Subscriber its conversion (individual) benefit plan, if the Member lives in the Sanford Health Plan Service Area. There may be other coverage options for the Subscriber and/or Eligible Dependents through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." The cost of these options may vary depending on a Subscriber's individual circumstances. To learn more, visit www.healthcare.gov or call 1-800-318-2596 | TTY/TDD: 1-855-889-4325.

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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 Members of the group health plan. It is the Plan Administrator's responsibility to notify Members of the termination of coverage.

Notice of Creditable Coverage

You, the Member, may request a Certificate of Creditable Coverage for you and your covered family Members upon your voluntary or involuntary termination from the Plan. You may also request a Certificate of Creditable Coverage at any time by calling Member Services toll-free at 1-800-499-3416 | TTY/TDD: 1-877-652-1844 (toll-free). Written requests can be sent to MemberServices@sanfordhealth.org or:
Sanford Health Plan
ATTN: NDPERS/Member Services
PO Box 91110
Sioux Falls, SD 57109-1110

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Section 12. Options After Coverage Ends

Federal Continuation of Coverage Provisions ("COBRA")

Notice of Continuation Coverage Rights Under COBRA

Introduction

You're getting this notice because you recently gained coverage under a group health plan (the Plan). 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 the Plan Administrator.

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), even if that plan generally doesn't 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 must be offered to each person who is a "qualified beneficiary." You, your spouse, 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 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 dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

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
- 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 NDPERS, 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, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

When is COBRA 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 the Plan Administrator 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).

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For all other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's 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:

North Dakota Public Employees Retirement System
400 East Broadway, Suite 505
PO Box 1657
Bismarck, ND 58502
(701) 328-3900

How is COBRA 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, 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:

- *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 must last at least until the end of the 18-month period of COBRA continuation coverage.
- *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 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 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 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, Medicaid, or other group health plan coverage options (such as a spouse'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.

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.

Plan Contact Information

Sanford Health Plan
300 Cherapa Place, Suite 201
Sioux Falls, SD 57103
(877) 305-5463 *(toll-free)*
TTY/TDD: (877) 652-1844 *(toll-free)*

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Section 13. Subrogation and Right of Reimbursement

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

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

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

Plan's Rights of Subrogation

In the event of any payments for benefits provided to a Member under this Contract, the Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member, the Member'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 Reasonable Cost for the services provided by the Plan. In providing benefits to a Member, the 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 Reasonable Costs of the benefits provided to the Member. Regardless of any such arrangement, when a Member receives a benefit under the Plan for an illness or injury, the Plan is subrogated to the Member's right to recover the Reasonable Costs of the benefits it provides on account of such illness or injury, even if those Reasonable Costs exceed the amount paid by the Plan.

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

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

Plan's Right to Reduction and Reimbursement

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

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

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

Member's Responsibilities

The Member, the Member'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 Member shall take no action prejudicing the rights and interests of the Plan under this provision. Neither a Member nor the Member'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. Any Member who fails to cooperate in the Plan's administration of this Part shall be responsible for the Reasonable Cost for services subject to this section and any legal costs incurred by the Plan to enforce its rights under this section. Members must also report any recoveries from insurance companies or other persons or organizations arising form or relating to an act or omission that caused or contributed to an injury or illness to the Member paid for by the Plan. Failure to comply will entitle the Plan to withhold benefits, services, payments, or credits due under the Plan.

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Attachment I. Summary of Benefits and Coverage

This page is intentionally left blank. Your *Summary of Benefits and Coverage* is an attachment to this Certificate of Insurance.

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