Sanford Health Plan
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SANFORD
HEALTH PLAN

Dear Future Member:

Sanford Health Plan welcomes you into our integrated system of care. We know you have a variety of options when it comes to making your health insurance decisions – so thank you for your interest in Sanford Health Plan!

As a health plan accredited with the National Committee for Quality Assurance (NCQA), Sanford Health Plan is required to provide you with additional information as you make decisions regarding your medical benefit plan. In this material, you will find the following:

- Provider Network
- Pharmacy Listing
- Pharmacy Handbook
- Pharmacy Formulary
- Member Handbook
- Special Notices

Feel free to contact Sanford Health Plan with any questions that you may have at (701) 751-4125 or toll-free at (800) 499-3416.

NDPERS Provider Network

Selecting a Health Care Provider

The benefit payment available under this Benefit Plan differs depending on your choice of Health Care Providers. Providers are paid 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. To find out whether services from a particular Provider will be paid at the PPO Plan or Basic Plan level, search your Provider Directory on your account at www.sanfordhealthplan.com/memberlogin.

Finding Pharmacies in Our Network and Your Formulary

Sanford Health Plan has contracted with Express Scripts Inc. to deliver your prescription medication and diabetes supplies benefits.

Plan Participating Pharmacies

You must fill the prescription, and show your Sanford Health Plan Member ID card, at a Plan Participating pharmacy for Cost Sharing amounts to apply. You 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 more from you than your Cost Sharing Amount. All claims from a Participating Pharmacy must be submitted by the Participating Pharmacy. You can request a Sanford Health Plan Participating Pharmacy Listing by calling (701) 751-4125 or (800) 499-3416 or view it online at www.sanfordhealthplan.com/memberlogin.

Non-Participating Pharmacies

If you choose to go to a Non-Participating pharmacy, you must pay the pharmacy directly for 100% of the costs of the medication at the time you receive it. You are then responsible for submitting a *Claim for Benefits Form* to the Plan for reimbursement. Payment for covered Prescription Medications will be sent to you. Any charges in excess of Allowed Charges are your responsibility. To obtain a form, call (800) 499-3416 | TTY/TDD: (877) 652-1844 or find it online at www.sanfordhealthplan.com/memberlogin.

Finding Participating Practitioners and Providers

Members should refer to the Sanford Health Plan website, www.sanfordhealthplan.com/memberlogin, for the Provider Directory, which lists Participating PPO and Basic Plan level Health Care Providers. As a member with Sanford Health Plan, you can simply enter the first 9 digits of your Member ID number and the directory will customize the results specific to your NDPERS network. 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 (800) 499-3416 (toll-free) or TTY/TDD: (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/memberlogin.

NOTE: Benefits for Covered Services received by Eligible 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.

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.

Practitioner Qualifications

If you would like additional information about your Practitioner's qualifications, please call Member Services at (800) 499-3416.

Special Communication Needs

Please call the Plan if you need help understanding 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.

After Hours Care

Your Primary Care Practitioner has agreed to be available to you twenty four (24) hours a day, seven (7) days a week for emergency and urgent care. Be sure to call during normal office hours for routine situations and only call after hours in URGENT or EMERGENCY situations. Leave a message with the answering service and, in accordance with Plan standards, your Primary Care Practitioner's office should return your call within thirty (30) minutes, or as soon as possible thereafter.

Emergency

If you have a condition requiring immediate surgical or medical attention, call 911 or go to the nearest emergency room for treatment. Sanford Health Plan covers any emergency services necessary to screen and stabilize you when a Prudent Layperson would reasonably believe that an Emergency Medical Condition exists. Preauthorization/Prior Approval is not needed to get Emergency services.

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, both within and outside of the Sanford Health Plan Service Area. If an Emergency Medical Condition arises, you are encouraged to seek services at the nearest Emergency Facility that is a Participating Provider. If the Emergency Medical Condition is such that you cannot go safely to the nearest Participating Emergency Facility, then you should seek care at the nearest Emergency Facility. To find a listing of Participating Emergency Providers and Facilities, log into your account at www.sanfordhealthplan.com/memberlogin or call the Plan toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (toll-free).

You, or a designated relative or friend must notify the Plan, and your 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 you are physically or mentally able to do so.

If you are admitted as an inpatient to a Non-Participating Provider Facility, 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, you may be transferred to a Participating Hospital and/or other appropriate Facility.

Note: If the Plan determines your condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts may apply, subject to whether services were received from a PPO-level or Basic-level Participating Provider/Facility, and if applicable, limitations on Non-Participating Providers as set forth in your Certificate of Insurance.

When you are outside of the Sanford Health Plan Service Area

PHCS Healthy Directions and MultiPlan Networks*

If you or any one of your family members live, travel or attend school outside of the Plans service area, log on to www.sanfordhealthplan.com/memberlogin to locate a participating provider.

Pharmacy Network

Participating Chain Provider Listing

North Dakota Public Employees Retirement System | SANFORD HEALTH PLAN

A & P
ACME
ALBERTSON'S
AURORA
B & B
BAKERS
BARTELL DRUG
BEL AIR
BI-LO
BI-MART
BIOSCRIP
BLOOM
BROOKSHIRE
BROOKSHIRE BROTHERS
BUSCH'S
CARRS
CITY MARKET
COBORNS
COPPS FOOD CENTER
COSTCO
CUB
CURASCRIPT
CVS
D & W
DIERBERGS
DILLON
DISCOUNT DRUG MART
DOC'S DRUGS
DOMINICK'S
DRUG WAREHOUSE
DRUG WORLD
DRUGS FOR LESS
ECKERD DRUGS
FAIRVIEW
FAMILY FARE
FARM FRESH
FOOD CITY
FOOD LION
FOOD MAXX
FOOD WORLD
FRED MEYER
FRED'S
FRUTH
FRY'S FOOD AND DRUG
GERBES
GIANT EAGLE
GIANT PHARMACY
GLEN'S
HAGGEN FOOD & DRUG
HANNAFORD
HARPS
HARRIS TEETER
HARVEYS SUPERMARKET
H-E-B
HEN HOUSE
HIGHPOINT
HOMELAND
HY-VEE
INGLES
KASH N' KARRY
KERR DRUG
KING SOOPERS
KINNEY DRUGS
KLINGENSMITH'S
KMART
KNIGHT DRUGS
KOPP DRUG
KROGER
LONGS DRUG
MARC'S
MARSH DRUG STORE
MARTIN'S
MED-FAST
MED-X DRUG
MEIJER
NAVARRO DISCOUNT
NEIGHBORCARE
NOB HILL
OMNICARE
OSCO
P & C
PAMIDA
PATHMARK
PATIENT FIRST
PAVILIONS
PAYLESS
PHARMACARE
PHARMACY EXPRESS
PHARMERICA
PICK N SAVE
PINE KNOB
PRICE CHOPPER
PUBLIX
QUICK CHEK
RAINBOW FOODS
RALEY'S
RALPH'S
RANDALLS
RECEPT PHARMACY
REDNER'S
RITE AID
SAFEWAY
SAM'S CLUB
SAVE MART
SAVERITE
SAV-MOR
SAV-ON
SCHNUCKS
SHAW'S
SHOP 'N SAVE
SHOPKO
SHOPPERS
SHOPRITE
SMITH'S FOOD AND DRUG
SNYDER DRUG
SOUTHERN FAMILY MARKET
STAR DRUG
STOP & SHOP
SUPER 1
SUPER D DRUGS
SUPER FERSH
SWEETBAY SUPERMARKET
TARGET
THRIFTY WHITE
TOM THUMB
TOP FOOD & DRUG
TOPS
UKROP'S
UNITED
USA DRUG
VALLEY DRUG
VG'S PHARMACY
VONS
WALDBAUM'S
WALGREENS
WAL-MART
WEGMANS
WEIS
WHITE DRUG
WINN-DIXIE

Pharmacy Handbook

for NDPERS grandfathered members

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Formulary

The 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. Selection criteria include clinical efficacy, safety, and cost effectiveness. Additional medications may be added or removed from the Formulary throughout the year. Sanford Health Plan will publish these changes and notify you by mail if any of the changes impact your cost sharing or accessibility. By logging into your *my*SanfordHealthPlan account at www.sanfordhealthplan.com/memberlogin, you can find additional information including: a complete listing of the formulary, pharmacy locator, generic substitution information, drug side effect/interaction and other benefit information.

To be covered by the Plan, medications must be:

1. Prescribed by a licensed health care professional within the scope of his or her practice;
2. Provided by a Participating Pharmacy except in the event of a medical emergency. If the prescription is obtained at a Non-Participating Pharmacy the Member is responsible for the prescription medication cost in full. 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. The Member should 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.
3. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

The information about the Formulary applies only to those medications, including injectable medications that may be covered under this Certificate of Insurance.

By following the Formulary, and asking your healthcare Practitioner for generic medications, you will save money and help control the costs of your health care. **If you request a brand-name medication when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic in addition to your copay.**

Pharmacy Programs

Please review the following information concerning the drug exclusion list, certification, quantity limits, step therapy and injectable medication programs. If you have any questions or concerns, contact Pharmacy Management at (888) 315-0885, option #1.

Mail Order Programs

Sanford Health Plan offers mail order services through Express Scripts, Inc. To enroll in this service, or if you have questions regarding this program call (800) 243-9800.

Injectable and High Cost Medications Program

Sanford Health Plan has contracted with Express Scripts Specialty Pharmacy *(Accredo)* for specialty medication needs. You can obtain injectable and high cost medications two different ways:

- From Accredo
- From an approved retail pharmacy or Practitioner's office

It is important to obtain approval (preauthorization/prior approval) from Sanford Health Plan before using these medications listed on the following page. If these medications are obtained from a Non-Participating pharmacy or a Practitioner's office without prior approval by the Pharmacy Management Department, the Member may be responsible for the full cost of the medication.

Accredo's toll-free customer service is available by calling (866) 333-9721, 24 hours a day, 365 days a year. You can:

- Order your injectable medications
- Consult with experienced, knowledgeable pharmacists
- Ask a specially trained nurse about your injectable medication

When calling *Accredo*, a customer service representative will ask you the following information:

- **Your name and date of birth**
- **Your phone number and address**
- **The name of your injectable medication to be filled**
- **Your doctor's name and phone number**

Accredo will mail your Practitioner a letter explaining the program. By participating in Specialty Care, you are automatically enrolled in a drug therapy management program. This program entitles you to receive the following benefits at no additional charge:

- Access to nurses and pharmacists 24 hours/day, 7 days/week for questions related to your injectable drug and the illness the drug is treating.
- Injectable drug refill reminders if you forget to call for your refill, and convenient refill process.
- Free delivery of your medication and supplies to your home, Practitioner's office or designated location.

If you order from *Accredo,* they will ship your medication and all the supplies you need for your injection directly to your home or Practitioner's office within 24 to 48 hours after the request is approved and medication is ordered. Administration supplies (syringes, needles etc.) will be included in the shipment. Prior to all shipments, a Patient Admission Specialist will contact you to discuss your cost for the medication and arrange delivery.

The medications on this list covered under the medical benefit are subject to your deductible/coinsurance. The medications covered under the pharmacy benefit are subject to cost sharing. To obtain preauthorization/prior approval or determine how the medications will be covered, call the Pharmacy Management at (888) 315-0885, option #1 / TTY/TDD: (877) 652-1844.

Note: Generic drugs are indicated in bold. Brand name drugs are listed in CAPITAL letters.

Disclaimer: Some of the medications listed below are subject to Step Therapy. Contact the Pharmacy Management Department for details.

Name	Disease State	Coverage	Preferred Alternatives
8-MOP	SKIN PREPS	MEDICAL	
ABRAXANE	CANCER	MEDICAL	
ACTEMRA IV	IMMUNOSUPPRESANT	MEDICAL	
ACTEMRA Subcutaneous	IMMUNOSUPPRESANT	BRAND NAME FORMULARY- Step Therapy Rules Apply	ENBREL, HUMIRA-BRAND NAME FORMULARY
ACTHAR H.P.	HORMONES	MEDICAL	
ACTIMMUNE	CANCER	MEDICAL	
ADCETRIS	CANCER	MEDICAL - LIMITED DISTRIBUTION	
ADCIRCA	CARDIOVASCULAR	BRAND NAME FORMULARY	
ADEMPAS	CARDIOVASCULAR	BRAND NAME FORMULARY	
ADRUCIL	CANCER	MEDICAL	
ADVATE	HEMOPHILIA	MEDICAL	
AFINITOR	CANCER	MEDICAL	
ALDURAZYME	ENZYME DEFICIENCIES	MEDICAL	
ALFERON N	CANCER	MEDICAL	
ALIMTA	CANCER	MEDICAL	
ALKERAN	CANCER	MEDICAL	
ALPHANATE	HEMOPHILIA	MEDICAL	
ALPHANINE SD	HEMOPHILIA	MEDICAL	
ALPROLIX	HEMOPHILIA	MEDICAL	
AMEVIVE	INFLAMMATORY CONDITION	MEDICAL	
AMIFOSTINE	CANCER	MEDICAL	
AMPYRA	MULTIPLE SCLEROSIS	BRAND NAME FORMULARY	
APOKYN	ANTIPARKINSON DRUGS	BRAND NAME FORMULARY	
ARALAST NP	RESPIRATORY CONDITIONS	MEDICAL	
ARANESP	BLOOD CELL DEFICIENCY	BRAND NAME FORMULARY	
ARCALYST	INFLAMMATORY CONDITION	MEDICAL	
AREDIA	BONE CONDITIONS	MEDICAL	
ARESTIN	ANTIINFECTIVES	BRAND NAME FORMULARY	
ARRANON	CANCER	MEDICAL	
ARZERRA	CANCER	MEDICAL	
ATGAM	IMMUNE DEFICIENCY	MEDICAL	
AUBAGIO	MULTIPLE SCLEROSIS	BRAND NAME FORMULARY - Step Therapy Rules Apply	
AVASTIN	CANCER	MEDICAL	
AVONEX	MULTIPLE SCLEROSIS	BRAND NAME FORMULARY	
AZACITIDINE	CANCER	MEDICAL	
BEBULIN	HEMOPHILIA	MEDICAL	
BENEFIX	HEMOPHILIA	MEDICAL	
BENLYSTA	SYSTEMIC LUPUS ERYTHEMATOUS	MEDICAL	
BERINERT	HEREDITARY ANGIOEDEMA	MEDICAL	
BEXXAR	CANCER	MEDICAL - LIMITED DISTRIBUTION	
BICNU	CANCER	MEDICAL	
BIVIGAM	IMMUNE DEFICIENCY	MEDICAL	
BLEOMYCIN SULFATE	CANCER	MEDICAL	
BOSULIF	CANCER	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
BOTOX	NEUROMUSCULAR CONDITION	MEDICAL	
BUSULFEX	CANCER	MEDICAL	
CALCIUM FOLINATE	CANCER	MEDICAL	
CAMPTOSAR	CANCER	MEDICAL	
CAPECITABINE	CANCER	MEDICAL	
CARBAGLU	GENETIC DISORDER	MEDICAL	
CARBOPLATIN	CANCER	MEDICAL	
CARIMUNE NF NANOFILTERED	IMMUNE DEFICIENCY	MEDICAL	
CAYSTON	ANTIBIOTICS	BRAND NAME FORMULARY - LIMITED DISTRIBUTION	
CELLCEPT	IMMUNOSUPPRESANT	MEDICAL	
CEPROTIN	BLOOD	MEDICAL	
CEREDASE	ENZYME DEFICIENCIES	BRAND NAME FORMULARY	
CEREZYME	ENZYME DEFICIENCIES	MEDICAL	
CERUBIDINE	CANCER	MEDICAL	
CHENODAL	INFLAMMATORY CONDITION	BRAND NAME FORMULARY - LIMITED DISTRIBUTION	
CIMZIA	INFLAMMATORY CONDITION	BRAND NAME FORMULARY - Step Therapy Rules Apply	ENBREL, HUMIRA-BRAND NAME FORMULARY
CINRYZE	HEREDITARY ANGIOEDEMA	MEDICAL	
CISPLATIN	CANCER	MEDICAL	
CLADRIBINE	CANCER	MEDICAL	
CLOLAR	CANCER	MEDICAL	
COPAXONE	MULTIPLE SCLEROSIS	BRAND NAME FORMULARY	
COPEGUS	HEPATITIS C	BRAND NAME FORMULARY	
CORIFACT	HEMOPHILIA	MEDICAL	
COSENTYX	INFLAMMATORY CONDITION	BRAND NAME FORMULARY	
COSMEGEN	CANCER	MEDICAL	
CYCLOPHOSPHAMIDE	CANCER	MEDICAL	
CYCLOSPORINE	IMMUNOSUPPRESANT	MEDICAL	
CYSTAGON	MISCELLANEOUS SPECIALTY CONDITIONS	BRAND NAME FORMULARY - LIMITED DISTRIBUTION	
CYTARABINE	CANCER	MEDICAL	
CYTOGAM	IMMUNE DEFICIENCY	MEDICAL	
DACARBAZINE	CANCER	MEDICAL	
DACOGEN	CANCER	MEDICAL	
DACTINOMYCIN	CANCER	MEDICAL	
DAUNORUBICIN HCL	CANCER	MEDICAL	
DAUNOXOME	CANCER	MEDICAL	
DDAVP	HORMONES	MEDICAL	
DECITABINE	CANCER	MEDICAL	
DEFEROXAMINE MESYLATE	IRON TOXICITY	MEDICAL	
DEPOCYT	CANCER	MEDICAL	
DESFERAL	IRON TOXICITY	MEDICAL	
DESMOPRESSIN ACETATE	HORMONES	MEDICAL	
DOCEFREZ	CANCER	MEDICAL	
DOCETAXEL	CANCER	MEDICAL	
DYSPORT	NEUROMUSCULAR CONDITION	MEDICAL	
ELAPRASE	ENZYME DEFICIENCIES	MEDICAL	
ELELYSO	ENZYME DEFICIENCIES	MEDICAL - LIMITED DISTRIBUTION	
ELIGARD	CANCER	MEDICAL	
ELITEK	ANTIARTHRITICS	MEDICAL	
ELLENCE	CANCER	MEDICAL	
ELOCTATE	HEMOPHILIA	BRAND NAME FORMULARY	
ELOXATIN	CANCER	MEDICAL	
ELSPAR	CANCER	MEDICAL	
ENBREL	INFLAMMATORY CONDITION	BRAND NAME FORMULARY	
enoxaparin sodium	ANTICOAGULANTS	**GENERIC FORMULARY** - Available through retail	
ENTYVIO	INFLAMMATORY CONDITION	MEDICAL - Step Therapy Rules Apply	ENBREL, HUMIRA-BRAND NAME FORMULARY
EPIRUBICIN HCL	CANCER	MEDICAL	
EPOGEN	BLOOD CELL DEFICIENCY	BRAND NAME FORMULARY	
EPOPROSTENOL SODIUM	CARDIOVASCULAR	MEDICAL	
ERBITUX	CANCER	MEDICAL	
ERIVEDGE	CANCER	MEDICAL	
ERWINAZE	CANCER	MEDICAL	
ESBRIET	RESPIRATORY CONDITIONS	BRAND NAME FORMULARY	
ETHYOL	CANCER	MEDICAL	
ETOPOPHOS	CANCER	MEDICAL	
ETOPOSIDE	CANCER	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
EUFLEXXA	ANTIARTHRITICS	MEDICAL	
EXJADE	IRON TOXICITY	MEDICAL	
EXTAVIA	MULTIPLE SCLEROSIS	BRAND NAME FORMULARY	
EYLEA	OPTHALMIC CONDITIONS	MEDICAL	
FABRAZYME	ENZYME DEFICIENCIES	MEDICAL	
FASLODEX	CANCER	MEDICAL	
FEIBA NF	HEMOPHILIA	MEDICAL	
FEIBA VH IMMUNO	HEMOPHILIA	MEDICAL	
FERRIPROX	IRON TOXICITY	BRAND NAME FORMULARY - LIMITED DISTRIBUTION	
FIRAZYR	HEREDITARY ANGIOEDEMA	BRAND NAME FORMULARY	
FIRMAGON	CANCER	MEDICAL	
FLEBOGAMMA DIF	IMMUNE DEFICIENCY	MEDICAL	
FLOLAN	CARDIOVASCULAR	MEDICAL	
FLOXURIDINE	CANCER	MEDICAL	
FLUDARA	CANCER	MEDICAL	
FLUDARABINE PHOSPHATE	CANCER	MEDICAL	
FLUOROURACIL	CANCER	MEDICAL	
FOLOTYN	CANCER	MEDICAL	
fondaparinux sodium	ANTICOAGULANTS	**GENERIC FORMULARY** - Available through retail	
FORTEO	BONE CONDITIONS	BRAND NAME FORMULARY	**alendronate - GENERIC FORMULARY**
FRAGMIN	ANTICOAGULANTS	BRAND NAME FORMULARY - Available through retail	**enoxaparin, fondaprinux - GENERIC FORMULARY**
FUSILEV	CANCER	MEDICAL	
FUZEON	ANTIVIRALS	MEDICAL	
GAMASTAN S-D	IMMUNE DEFICIENCY	MEDICAL	
GAMMAGARD LIQUID	IMMUNE DEFICIENCY	MEDICAL	
GAMMAGARD S-D	IMMUNE DEFICIENCY	MEDICAL	
GAMMAKED	IMMUNE DEFICIENCY	MEDICAL	
GAMMAPLEX	IMMUNE DEFICIENCY	MEDICAL	
GAMUNEX	IMMUNE DEFICIENCY	MEDICAL	
GAMUNEX-C	IMMUNE DEFICIENCY	MEDICAL	
GATTEX	INFLAMMATORY CONDITION	MEDICAL	
GAZYVA	CANCER	MEDICAL	
GEL-ONE	ANTIARTHRITICS	MEDICAL	
GEMCITABINE HCL	CANCER	MEDICAL	
GEMZAR	CANCER	MEDICAL	
GILENYA	MULTIPLE SCLEROSIS	BRAND NAME FORMULARY - Step Therapy Rules Apply	AVONEX, COPAXONE, REBIF - BRAND NAME FORMULARY
GILOTRIF	CANCER	MEDICAL	
GLASSIA	RESPIRATORY CONDITIONS	MEDICAL	
GLEEVEC	CANCER	MEDICAL	
GRANIX	BLOOD CELL DEFICIENCY	BRAND NAME FORMULARY	
HALAVEN	CANCER	MEDICAL	
HARVONI	HEPATITIS C	BRAND NAME FORMULARY - PA Required	PEGASYS, VIEKIRA - BRAND NAME FORMULARY
HELIXATE FS	HEMOPHILIA	MEDICAL	
HEMOFIL-M	HEMOPHILIA	MEDICAL	
HEPAGAM B	IMMUNE DEFICIENCY	MEDICAL	
HERCEPTIN	CANCER	MEDICAL	
HIZENTRA	IMMUNE DEFICIENCY	MEDICAL	
HUMATE-P	HEMOPHILIA	MEDICAL	
HUMATROPE	GROWTH HORMONE	BRAND NAME FORMULARY	
HUMIRA	ANTIARTHRITICS	BRAND NAME FORMULARY	
HYALGAN	ANTIARTHRITICS	MEDICAL	
HYCAMTIN	CANCER	MEDICAL	
HYPERHEP B S-D	IMMUNE DEFICIENCY	MEDICAL	
HYPERRAB S-D	IMMUNE DEFICIENCY	MEDICAL	
HYPERRHO S-D	IMMUNE DEFICIENCY	MEDICAL	
IBANDRONATE SODIUM	BONE CONDITIONS	MEDICAL	
IDAMYCIN PFS	CANCER	MEDICAL	
IDARUBICIN HCL	CANCER	MEDICAL	
IFEX	CANCER	MEDICAL	
IFOSFAMIDE-/MESNA	CANCER	MEDICAL	
ILARIS	INFLAMMATORY CONDITION	MEDICAL	
IMOGAM RABIES-HT	IMMUNE DEFICIENCY	MEDICAL	
INCRELEX	HORMONES	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
INFERGEN	HEPATITIS C	BRAND NAME FORMULARY - PA Required	PEGASYS, VIEKIRA-BRAND NAME FORMULARY
INLYTA	CANCER	MEDICAL	
INTRON A	CANCER	MEDICAL	
IPRIVASK	ANTICOAGULANTS	BRAND NAME FORMULARY - Available through retail	**enoxaparin, fondaparinux-GENERIC FORMULARY,** FRAGMIN - BRAND NAME FORMULARY
IRINOTECAN HCL	CANCER	MEDICAL	
ISTODAX	CANCER	MEDICAL	
IXEMPRA	CANCER	MEDICAL	
JAKAFI	CANCER	MEDICAL	
JEVTANA	CANCER	MEDICAL	
KADCYLA	CANCER	MEDICAL	
KALBITOR	HEREDITARY ANGIOEDEMA	MEDICAL	
KALYDECO	RESPIRATORY CONDITIONS	MEDICAL	
KEPIVANCE	INFLAMMATORY CONDITION	MEDICAL	
KINERET	ANTIARTHRITICS	BRAND NAME FORMULARY - Step Therapy Rules Apply	ENBREL, HUMIRA-BRAND NAME FORMULARY
KOATE-DVI	HEMOPHILIA	MEDICAL	
KOGENATE FS	HEMOPHILIA	MEDICAL	
KRYSTEXXA	ANTIARTHRITICS	MEDICAL	
KUVAN	PKU	MEDICAL	
KYNAMRO	CARDIOVASCULAR	MEDICAL	
KYPROLIS	CANCER	MEDICAL - LIMITED DISTRIBUTION	
LETAIRIS	CARDIOVASCULAR	BRAND NAME FORMULARY	
LEUKINE	BLOOD CELL DEFICIENCY	MEDICAL	
LEUPROLIDE ACETATE	CANCER	MEDICAL	
LEUSTATIN	CANCER	MEDICAL	
LUCENTIS	OPTHALMIC CONDITIONS	MEDICAL	
LUMIZYME	ENZYME DEFICIENCIES	MEDICAL	
LUPANETA PACK	HORMONES	MEDICAL	
LUPRON DEPOT	CANCER	MEDICAL	
LUPRON DEPOT-PED	HORMONES	MEDICAL	
MACUGEN	OPTHALMIC CONDITIONS	MEDICAL	
MEKINIST	CANCER	MEDICAL	
MELPHALAN HCL	CANCER	MEDICAL	
MESNA	CANCER	MEDICAL	
MESNEX	CANCER	MEDICAL	
methotrexate	CANCER	**GENERIC FORMULARY**	
MICRHOGAM PLUS	IMMUNE DEFICIENCY	MEDICAL	
MITOMYCIN	CANCER	MEDICAL	
MITOXANTRONE	CANCER	MEDICAL	
MODERIBA	ANTIVIRALS	BRAND NAME FORMULARY	
MONOCLATE-P	HEMOPHILIA	MEDICAL	
MONONINE	HEMOPHILIA	MEDICAL	
MONOVISC	ANTIARTHRITICS	MEDICAL	
MOZOBIL	BLOOD CELL DEFICIENCY	MEDICAL	
MUSTARGEN	CANCER	MEDICAL	
MYALEPT	HORMONES	BRAND NAME FORMULARY	
MYOBLOC	NEUROMUSCULAR CONDITION	MEDICAL	
MYOZYME	ENZYME DEFICIENCIES	MEDICAL	
NABI-HB	IMMUNE DEFICIENCY	MEDICAL	
NAGLAZYME	ENZYME DEFICIENCIES	MEDICAL	
NAVELBINE	CANCER	MEDICAL	
NEULASTA	BLOOD CELL DEFICIENCY	BRAND NAME FORMULARY	
NEUMEGA	BLOOD CELL DEFICIENCY	MEDICAL	
NEUPOGEN	BLOOD CELL DEFICIENCY	BRAND NAME FORMULARY	
NEXAVAR	CANCER	MEDICAL	
NIPENT	CANCER	MEDICAL	
NOVOSEVEN	HEMOPHILIA	MEDICAL	
NOVOSEVEN RT	HEMOPHILIA	MEDICAL	
NPLATE	BLOOD CELL DEFICIENCY	MEDICAL	
NULOJIX	IMMUNOSUPPRESANT	MEDICAL	
NUTROPIN	GROWTH HORMONE	BRAND NAME FORMULARY	
OCTAGAM	IMMUNE DEFICIENCY	MEDICAL	
OCTREOTIDE ACETATE	HORMONES	MEDICAL	
OFORTA	CANCER	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
OLYSIO	HEPATITIS C	BRAND NAME FORMULARY - PA Required	PEGASYS, VIEKIRA-BRAND NAME FORMULARY
OMONTYS	BLOOD CELL DEFICIENCY	BRAND NAME FORMULARY	
ONCASPAR	CANCER	MEDICAL	
ONSOLIS	ANALGESICS	BRAND NAME FORMULARY	
OPSUMIT	CARDIOVASCULAR	BRAND NAME FORMULARY	
ORALAIR	IMMUNE DEFICIENCY	BRAND NAME FORMULARY	
ORENCIA IV	ANTIARTHRITICS	MEDICAL	
ORENCIA SC	ANTIARTHRITICS	BRAND NAME FORMULARY - Step Therapy Rules Apply	ENBREL, HUMIRA-BRAND NAME FORMULARY
ORENITRAM ER	CARDIOVASCULAR	BRAND NAME FORMULARY	
ORTHOCLONE OKT-3	IMMUNOSUPPRESANT	MEDICAL - LIMITED DISTRIBUTION	
ORTHOVISC	ANTIARTHRITICS	MEDICAL	
OTEZLA	ANTIARTHRITICS	BRAND NAME FORMULARY - LIMITED DISTRIBUTION - Step Therapy Rules Apply	ENBREL, HUMIRA-BRAND NAME FORMULARY
OXALIPLATIN	CANCER	MEDICAL	
OZURDEX	OPTHALMIC CONDITIONS	BRAND NAME FORMULARY	
PACLITAXEL	CANCER	MEDICAL	
PAMIDRONATE DISODIUM	BONE CONDITIONS	MEDICAL	
PANRETIN	CANCER	MEDICAL	
PEGASYS/PROCLICK/REDIPEN	HEPATITIS C	BRAND NAME FORMULARY - PA Required	
PEG-INTRON	HEPATITIS C	MEDICAL	
PERJETA	CANCER	MEDICAL	
PHOTOFRIN	CANCER	MEDICAL	
PLEGRIDY	MULTIPLE SCLEROSIS	BRAND NAME FORMULARY	
POMALYST	CANCER	MEDICAL	
PRIVIGEN	IMMUNE DEFICIENCY	MEDICAL	
PROCRIT	BLOOD CELL DEFICIENCY	BRAND NAME FORMULARY	
PROCYSBI	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
PROFILNINE SD	HEMOPHILIA	MEDICAL	
PROGRAF	IMMUNOSUPPRESANT	INFUSION-MEDICAL ORAL - BRAND NAME FORMULARY	
PROLASTIN	RESPIRATORY CONDITIONS	MEDICAL	
PROLASTIN C	RESPIRATORY CONDITIONS	MEDICAL - LIMITED DISTRIBUTION	
PROLEUKIN	CANCER	MEDICAL	
PROLIA	BONE CONDITIONS	BRAND NAME FORMULARY	**alendronate - GENERIC FORMULARY**
PROMACTA	BLOOD CELL DEFICIENCY	BRAND NAME FORMULARY	
PULMOZYME	RESPIRATORY CONDITIONS	BRAND NAME FORMULARY	
REBETOL	HEPATITIS C	BRAND NAME FORMULARY	
REBIF	MULTIPLE SCLEROSIS	BRAND NAME FORMULARY	
RECLAST	BONE CONDITIONS	MEDICAL	**alendronate - GENERIC FORMULARY**
RECOMBINATE	HEMOPHILIA	MEDICAL	
REFLUDAN	ANTICOAGULANTS	BRAND NAME FORMULARY - available through retail	**enoxaparin, fondaparinux - GENERIC FORMULARY**, FRAGMIN - BRAND NAME FORMULARY
REMICADE	INFLAMMATORY CONDITION	MEDICAL - Step Therapy Rules Apply	ENBREL, HUMIRA-BRAND NAME FORMULARY
REMODULIN	CARDIOVASCULAR	BRAND NAME FORMULARY	
RETROVIR	ANTIVIRALS	MEDICAL	
REVATIO	CARDIOVASCULAR	BRAND NAME FORMULARY	
REVLIMID	CANCER	MEDICAL	
RHOGAM PLUS	IMMUNE DEFICIENCY	MEDICAL	
RHOPHYLAC	IMMUNE DEFICIENCY	MEDICAL	
RIASTAP	BLOOD DISORDER	BRAND NAME FORMULARY	
RIBAPAK	HEPATITIS C	BRAND NAME FORMULARY	RIBAVIRIN - BRAND NAME FORMULARY
RIBASPHERE	HEPATITIS C	BRAND NAME FORMULARY	
RIBATAB	HEPATITIS C	BRAND NAME FORMULARY	RIBAVIRIN - BRAND NAME FORMULARY
RIBAVIRIN	HEPATITIS C	BRAND NAME FORMULARY	

Name	Disease State	Coverage	Preferred Alternatives
RILUTEK	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
RITUXAN	CANCER	MEDICAL	
RIXUBIS	HEMOPHILIA	MEDICAL	
RUCONEST	HEREDITARY ANGIOEDEMA	BRAND NAME FORMULARY	
SABRIL	ANTICONVULSANT	BRAND NAME FORMULARY	
SANDIMMUNE	IMMUNOSUPPRESANT	MEDICAL	
SANDOSTATIN	HORMONES	MEDICAL	
SIGNIFOR	HORMONES	MEDICAL	
sildenafil citrate	CARDIOVASCULAR	**GENERIC FORMULARY**	
SIMPONI	ANTIARTHRITICS	BRAND NAME FORMULARY - Step Therapy Rules Apply	ENBREL, HUMIRA-BRAND NAME FORMULARY
SIMPONI ARIA	ANTIARTHRITICS	BRAND NAME FORMULARY - Step Therapy Rules Apply	ENBREL, HUMIRA
SIMULECT	IMMUNOSUPPRESANT	MEDICAL	
SIPULEUCEL-T PROVENGE	CANCER	MEDICAL	
SOLIRIS	BLOOD DISORDER	MEDICAL	
SOMATULINE DEPOT	HORMONES	BRAND NAME FORMULARY	
SOMAVERT	GROWTH HORMONE	BRAND NAME FORMULARY	
SOVALDI	HEPATITIS C	BRAND NAME FORMULARY - PA Required	
SPRYCEL	CANCER	MEDICAL	
STELARA	IMMUNOSUPPRESANT	BRAND NAME FORMULARY - Step Therapy Rules Apply	ENBREL, HUMIRA-BRAND NAME FORMULARY
STIVARGA	CANCER	MEDICAL	
SUCRAID	INFLAMMATORY CONDITION	BRAND NAME FORMULARY	
SUPARTZ	ANTIARTHRITICS	MEDICAL	
SUPPRELIN LA	HORMONES	MEDICAL	
SUTENT	CANCER	MEDICAL	
SYLATRON	CANCER	MEDICAL	
SYLATRON 4-PACK	CANCER	MEDICAL	
SYLVANT	CANCER	MEDICAL	
SYNAGIS	RSV PREVENTION	MEDICAL	
SYNVISC/ ONE	ANTIARTHRITICS	MEDICAL	
TAFINLAR	CANCER	MEDICAL	
TARCEVA	CANCER	MEDICAL	
TASIGNA	CANCER	MEDICAL	
TAXOTERE	CANCER	MEDICAL	
TECFIDERA	MULTIPLE SCLEROSIS	BRAND NAME FORMULARY - Step Therapy Rules Apply	AVONEX, COPAXONE, REBIF - BRAND NAME FORMULARY
TEMODAR	CANCER	MEDICAL	
TEMOZOLOMIDE	CANCER	MEDICAL	
TESTOPEL	HORMONES	MEDICAL - LIMITED DISTRIBUTION	
THALOMID	CANCER	MEDICAL	
THERACYS	CANCER	MEDICAL	
THIOTEPA	CANCER	MEDICAL	
THYMOGLOBULIN	IMMUNE DEFICIENCY	MEDICAL	
THYROGEN	CANCER	MEDICAL	
TICE BCG	CANCER	MEDICAL	
TOBI	ANTIBIOTICS	BRAND NAME FORMULARY	
tobramycin sulfate	ANTIBIOTICS	**GENERIC FORMULARY**	
TOPOSAR	CANCER	MEDICAL	
TOPOTECAN HCL	CANCER	MEDICAL	
TORISEL	CANCER	MEDICAL	
TRACLEER	CARDIOVASCULAR	BRAND NAME FORMULARY	
TREANDA	CANCER	MEDICAL	
TRELSTAR DEPOT	CANCER	MEDICAL	
TRELSTAR LA	CANCER	MEDICAL	
TRETTEN	HEMOPHILIA	MEDICAL	
TRISENOX	CANCER	MEDICAL	
TYKERB	CANCER	MEDICAL	
TYSABRI	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL - Step Therapy Rules Apply	AVONEX, COPAXONE, REBIF - BRAND NAME FORMULARY
TYVASO	CARDIOVASCULAR	MEDICAL	
VALCHLOR	CANCER	MEDICAL	
VALSTAR	CANCER	MEDICAL	
VANDETANIB	CANCER	MEDICAL	
VANTAS	CANCER	MEDICAL	
VECTIBIX	CANCER	MEDICAL	
VELCADE	CANCER	MEDICAL	

Name	Disease State	Coverage	Preferred Alternatives
VELETRI	CARDIOVASCULAR	MEDICAL	
VENTAVIS	CARDIOVASCULAR	MEDICAL	
VICTRELIS	HEPATITIS C	MEDICAL	
VIDAZA	CANCER	MEDICAL	
VIEKIRA PAK	HEPATITIS C	BRAND NAME FORMULARY	
VIMIZIM	ENZYME DEFICIENCIES	BRAND NAME FORMULARY	
VINBLASTINE SULFATE	CANCER	MEDICAL	
VINCASAR PFS	CANCER	MEDICAL	
VINCRISTINE SULFATE	CANCER	MEDICAL	
VINORELBINE TARTRATE	CANCER	MEDICAL	
VISUDYNE	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
VIVITROL	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
VOTRIENT	CANCER	MEDICAL	
VPRIV	ENZYME DEFICIENCIES	MEDICAL	
VUMON	CANCER	MEDICAL	
WINRHO SDF	IMMUNE DEFICIENCY	MEDICAL	
XALKORI	CANCER	MEDICAL	
XELJANZ	ANTIARTHRITICS	BRAND NAME FORMULARY - Step Therapy Rules Apply	ENBREL, HUMIRA-BRAND NAME FORMULARY
XELODA	CANCER	MEDICAL	
XENAZINE	GENETIC DISORDER	MEDICAL	
XEOMIN	NEUROMUSCULAR CONDITION	MEDICAL	
XGEVA	BONE CONDITIONS	MEDICAL	
XIAFLEX	MISCELLANEOUS SPECIALTY CONDITIONS	MEDICAL	
XOLAIR	ANTIASTHMATICS	MEDICAL	
XTANDI	CANCER	MEDICAL	
XYNTHA	HEMOPHILIA	MEDICAL	
XYNTHA SOLOFUSE	HEMOPHILIA	MEDICAL	
XYREM	SEDATIVE/HYPNOTICS	BRAND NAME FORMULARY - LIMITED DISTRIBUTION	
YERVOY	CANCER	MEDICAL - LIMITED DISTRIBUTION	
ZALTRAP	CANCER	MEDICAL	
ZANOSAR	CANCER	MEDICAL	
ZAVESCA	ENZYME DEFICIENCIES	MEDICAL	
ZELBORAF	CANCER	MEDICAL	
ZEMAIRA	RESPIRATORY CONDITIONS	MEDICAL	
ZEVALIN	CANCER	MEDICAL - LIMITED DISTRIBUTION	
ZOLADEX	CANCER	MEDICAL	
ZOLEDRONIC ACID	BONE CONDITIONS	MEDICAL	
ZOLINZA	CANCER	MEDICAL	
ZOMETA	BONE CONDITIONS	MEDICAL	
ZYKADIA	CANCER	MEDICAL	
ZYTIGA	CANCER	MEDICAL	

Note: PA/Preauthorization/prior approval

Infertility Services

Benefits are subject to a $500 Infertility Services Lifetime Deductible Amount and a $20,000 Lifetime Benefit Maximum Amount per Member. The medications listed below are available for coverage. Members are responsible for 20% of the allowed charge once the deductible is satisfied.

Covered Infertility Medications

Bravelle	Cetrotide
chorionic gonadotropin	clomiphene citrate
Follistim AQ	Ganirelix Acetate
Gonal- F/RFF/ Redi-Ject	Menopur
Ovidrel	Repronex

For additional information on infertility services, please refer to your Certificate of Insurance.

Step Therapy Program

A step therapy program means that you need to try certain medications before "stepping up" to other medications that are more expensive. This prescription medication program is designed to help keep costs down for you and your Plan as medications are becoming more and more expensive. Your Plan includes the following step therapy programs.

Antidepressent (SSRI and SNRI) Step Therapy

1. One generic medication will be required before a brand name medication is authorized. Generic medications must have been prescribed at an effective dose for a minimum of 34 days. Documentation of attempt and failure of a generic within the last 12 months will be considered as fulfilling this requirement.
    - Bupropion sr, xl
    - Citalopram
    - Duloxetine
    - Escitalopram
    - Fluoxetine 20 mg
    - Fluvoxamine
    - Mirtazapine
    - Paroxetine ir, cr
    - Sertraline
    - Venlafaxine ir, xr capsules and tablets
2. Pristiq will be covered (after a generic SSRI/ SNRI is tried a minimum of 34 days) at the brand name formulary cost sharing level.
3. Viibryd will be covered (after a generic SSRI/ SNRI is tried a minimum of 34 days) at the brand name formulary cost sharing level.

Crestor/Liptruzet/Zetia Step Therapy

- The Member must have a minimum 34 day trial of one of the following medications in the last 12 months for possible consideration
    - Atorvastatin
    - Fluvastatin
    - Lovastatin
    - Pravastatin
    - Simvatatin

Proton Pump Inhibitors (PPIs) Step Therapy

- A minimum 34 day trial of generic omeprazole, pantoprazole, and rabeprazole are required before approval of a non-formulary PPI will be considered.
- Prior authorization is required for lansoprazole solutabs, first lansoprazole and first omeprazole. This is based on medical necessity for all members over the age of 12 years.

Pre-Authorization/ Prior Approval

Drugs that Require Prospective (Pre-service) Review and Pre-Authorization/Prior Approval

For coverage of formulary exceptions, the following medications require a pre-authorization/prior approval of medical necessity. Fax the pre-authorization/prior approval to the Pharmacy Management Department at (701) 234-4568.

- Byetta; failure of covered oral medications
- Bydueron; failure of covered oral medications
- Omega – 3 Acid Ethyl Esters (generic Lovaza); Triglyceride level must be greater than 500
- Testosterone Products (Androderm, Androgel, Axiron, Testoderm, Testosterone Injectable); require two below normal testosterone levels within the last 6 months collected 30 days apart as well as symptoms of testosterone deficiency other than erectile dysfunction
- Symlin; failure of covered oral medications
- Trulicity; failure of covered oral medications
- Uloric: failure of generic allopurinol
- Victoza; failure of covered oral medications

Non Formulary Medication

The following medications (and their generic equivalent, if listed) are not included in our formulary, and are considered non-formulary. If your doctor prescribes one of these medications they are considered "covered or eligible" under your health benefits (per your Certificate of Insurance). These medications require preauthorization/prior approval and if approved, these medications will cost you more money because they are not on the formulary.

Non Formulary Medication	Preferred Alternatives
ACCU-CHECK METER/TEST STRIPS	One Touch Ultra, One Touch Ultramini, One Touch Verio
ACIPHEX	omeprazole, pantoprazole, rabeprazole
ACTONEL	alendronate, ibadronate
AEROSPAN	Pulmicort, Flovent, Qvar
ALOCRIL	Patanol, Pataday
ALOMIDE	Patanol, Pataday
ALORA	Vivelle-DOT
ALREX	Patanol, Pataday
ALTOPREV	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
ALVESCO	Pulmicort, Flovent, Qvar
AMBIEN CR	zolpidem, eszopiclone, zaleplon
ANGELIQ	Prempro, Premphase, Femhrt
ANTARA	fenofibrate generic, Trilipix
APIDRA	Novolog, Novolin
APIDRA SOLOSTAR	Novolog, Novolin
APRISO	Asacol, Delzicol, Pentasa, Lialda
ASMANEX	Pulmicort, Flovent, Qvar
ATELVIA	alendronate, ibadronate
ATRALIN	clindamycin-benzoyl perox, Epiduo, Differen
AVITA	clindamycin-benzoyl perox, Epiduo, Differen
AZOR	amlodipine + losartan
BECONASE AQ	Astepro
BENICAR	losartan, irbesartan, telmisartan
BENICAR HCT	losartan + HCTZ, irbesartan + HCTZ, telmisartan + HCTZ
BEPREVE	Patanol, Pataday
BESIVANCE	Vigamox
BETASERON	Avonex, Rebif, Copaxone
BEYAZ	generic orals, Ortho Tri Cyclen Lo, Nuvaring
BINOSTO	alendronate, ibadronate
BONIVA	alendronate, ibadronate
BREEZE 2	One Touch Ultra, One Touch Ultramini, One Touch Verio
BRINTELLIX	fluoxetine, paroxetine, Viibryd
BRISDELLE	fluoxetine, paroxetine, Viibryd
BROMDAY	Acuvail
BROVANA	Perforomist
CARDURA XL	alfuzosin, finasteride, tamsulosin
CENESTIN	Premarin
CIPRO HC	ofloxacin, Ciprodex
CLIMARA	Combipatch
CONTOUR METER/ TEST STRIPS	One Touch Ultra, One Touch Ultramini, One Touch Verio
DEXILANT	omeprazole, pantoprazole, rabeprazole
DIDGET	One Touch Ultra, One Touch Ultramini, One Touch Verio
DIPENTUM	Asacol, Delzicol, Pentasa, Lialda
DUEXIS	famotidine + ibuprofen
DULERA	Symbicort, Advair
DUREZOL	Lotemax
EDARBI	irbesartan, candasartan, losartan, telmisartan
EDARBYCLOR	irbesartan-HCTZ, candasartan-HCTZ, losartan-HCTZ, telmisartan-HCTZ
EDLUAR	zolpidem, eszopiclone, zaleplon
EFFEXOR XR	venlafaxine generic, Cymbalta
EMADINE	Patanol, Pataday
ENABLEX	Vesicare, Toviaz
ENJUVIA	Premarin
EXFORGE HCT	amlodipine + losartan + HCTZ
EXTAVIA	Avonex, Rebif, Copaxone
FEMTRACE	Premarin
FETZIMA	venlafaxine generic, Cymbalta

Non Formulary Medication	Preferred Alternatives
FIBRICOR	fenofibrate generic, Trilipix
FML FORTE	Lotemax
FORTESTA	Androgel, Axiron, Androderm
FOSAMAX PLUS D	alendronate, ibadronate
FREESTYLE METERS/TEST STRIPS	One Touch Ultra, One Touch Ultramini, One Touch Verio
GELNIQUE	Vesicare, Toviaz
GENERESS FE	generic orals, Ortho Tri Cyclen Lo, Nuvaring
GENOTROPIN	Nutropin, Humatrope
GLUMETZA	Onglyza, Kombiglyze, Janumet, Januvia
HUMALOG	Novolog, Novolin
HUMULIN VIAL/KWIKPEN	Novolog, Novolin
ILEVRO	Acuvail
INTERMEZZO	zolpidem, eszopiclone, zaleplon
JENTADUETO	Onglyza, Kombiglyze, Janumet, Januvia
KADIAN	Oxycontin
KAZANO	Onglyza, Kombiglyze, Janumet, Januvia
LASTACAFT	azelastine, Pataday, Patanol
LESCOL XL	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
LIPOFEN	fenofibrate generic, Trilipix
LIVALO	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
LO LOESTRIN FE	generic orals, Ortho Tri Cyclen Lo, Nuvaring
LO MINASTRIN FE	generic orals, Ortho Tri Cyclen Lo, Nuvaring
LUNESTA	zolpidem, eszopiclone, zaleplon
MAXAIR AUTOHALER	Ventolin HFA, Proair HFA
MENEST	Premarin
MENOSTAR	Vivelle-DOT
MICARDIS	irbesartan, candasartan, losartan, telmisartan
MICARDIS HCT	irbesartan-HCTZ, candasartan-HCTZ, losartan-HCTZ, telmisartan-HCTZ
MINASTRIN 24 FE	generic orals, Ortho Tri Cyclen Lo, Nuvaring
MINIVELLE	Vivelle-DOT
MOXEZA	Vigamox
MYRBETRIQ	Vesicare, Toviaz
NATAZIA	generic orals, Ortho Tri Cyclen Lo, Nuvaring
NESINA	Onglyza, Kombiglyze, Janumet, Januvia
NEVANAC	Acuvail
NEXIUM RX	omeprazole, pantoprazole, rabeprazole
NIZATIDINE	cimetidine, ranitidine, famotidine
NORDITROPIN	Nutropin, Humatrope
NUCYNTA ER	Oxycontin
OMNARIS	Astepro
OMNITROPE	Nutropin, Humatrope
OPANA ER	Oxycontin
ORACEA	doxycycline, minocycline, tetracycline
OSENI	Onglyza, Kombiglyze, Janumet, Januvia
OXYTROL	Vesicare, Toviaz
PATANASE	Astepro
PENNSAID	Flector, Voltaren
PRECISION METERS/ TEST STRIPTS	One Touch Ultra, One Touch Ultramini, One Touch Verio
PREVACID RX	omeprazole, pantoprazole, rabeprazole
PREVPAC	generic clarithromycin + amoxicillin + lansoprazole
PRILOSEC RX	omeprazole, pantoprazole, rabeprazole
PROLENSA	Acuvail
PROTONIX	omeprazole, pantoprazole, rabeprazole
PROVENTIL HFA	Ventolin HFA, Proair HFA
PROZAC	fluoxetine, paroxetine, Viibryd

Non Formulary Medication	Preferred Alternatives
QNASL	budesonide, flunisolide, Nasonex
QUARTETTE	generic orals, Ortho Tri Cyclen Lo, Nuvaring
RAPAFLO	alfuzosin, finasteride, tamsulosin
SAFYRAL	generic orals, Ortho Tri Cyclen Lo, Nuvaring
SAIZEN	Nutropin, Humatrope
SANCTURA XR	Vesicare, Toviaz
SANCUSO	ondansetron, granisetron
SAPHRIS	Abilify, Latuda
SILENOR	zolpidem, eszopiclone, zaleplon
SIMCOR	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
SOLODYN	doxycycline, minocycline, tetracycline
TESTIM	Androgel, Axiron, Androderm
TEVETEN	losartan, irbesartan, telmisartan
TEVETEN HCT	losartan + HCTZ, irbesartan + HCTZ, telmisartan + HCTZ
TRADJENTA	Onglyza, Kombiglyze, Janumet, Januvia
TRAVATAN Z	latanoprost, Lumigan
TREXIMET	sumatriptan, rizatriptan, Maxalt, Relpax
TRIBENZOR	amlodipine + losartan + HCTZ

Non Formulary Medication	Preferred Alternatives
TRIGLIDE	fenofibrate generic, Trilipix
TRUE METRIX METER/TEST STRIPS	One Touch Ultra, One Touch Ultramini, One Touch Verio
TWYNSTA	amlodipine + losartan
VASCEPA	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
VELTIN	clindamycin-benzoyl perox, Epiduo, Differen
VERAMYST	Astepro
VEXOL	Lotemax
VIMOVO	omeprazole + naproxen
VOGELXO	Androgel, Axiron, Androderm
VYTORIN	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
XOPENEX HFA	Ventolin HFA, Proair HFA
ZETONNA	Astepro
ZIANA	clindamycin-benzoyl perox, Epiduo, Differen
ZIOPTAN	Lumigan
ZOHYDRO ER	Oxycontin
ZOLPIMIST	zolpidem, eszopiclone, zaleplon

Quantity Limit List

The following medications do not require preauthorization/prior approval but have a quantity limit:
Anzemet—1 tablets/ prescription
Axert—6 tablets/prescription
butorphanol tartrate- nasal spray—2 spray bottles/ prescription
dihydroergotamine mesylate (generic Migranal)—8 spray/prescription
Emend—3 pills/prescription
Frova—9 tablets/prescription
granisetron (generic Kytril)—2 tablets/prescription
Lysteda- 30 tablets/prescription
naratriptan (generic Amerge)—9 tablets/prescription
Relpax—12 tablets/prescription
rizatriptan (generic Maxalt)—12 tablets/prescription
sumatriptan (generic Imitrex)—12 tablets/ 6 nasal spray or 1 kit for injections/prescription or 2 injections
Viagra – 18 tablets/ 90 days
Zomig—6 ampules/sprays/prescription
zolmitriptan(generic Zomig)—12 tablets / prescription

Limited and Non-Covered Services

Excluded Medications and Supplies

The following medications are specifically **EXCLUDED** from coverage under your Plan. However, by exception, a request for coverage may be considered if a regulation requiring coverage is in place, a formulary exception is made, or a previous pre-authorization/ prior approval has been granted by the Plan. Requests for coverage for these medications will not be considered unless you have tried and failed a Formulary alternative. To request a formulary exception or coverage of an excluded drug, contact the Pharmacy Management Department or complete the Medication Request Form found on your member account at www.sanfordhealthplan.com/memberlogin.

- 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)
- 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 (unless otherwise specified as covered in your COI), 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, prenatal vitamins with a prescription order) 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

Compounded medications that contain any combination of baclofen, cyclobenzaprine, ketamine, bupivacaine, orphendadrine, gabapentin, or ketoprofen are **NOT COVERED** due to lack of good quality scientific evidence of effectiveness or safety for these specific ingredient combinations and mode of administration.

Complaints and Appeals Procedure

If you receive an adverse determination to your request for an exception to the formulary, please follow the *Complaints and Appeals Procedure* and the *External Review Rights* in Section 8 and Section 5(e) found in your Certificate of Insurance. This applies to requests for coverage of non-covered medications, generic substitutions, therapeutic interchanges and step-therapy protocols.

Definitions

Brand Name Medication - A medication manufactured and marketed under a trademark or name by a specific medication manufacturer.

Clinic/Office/Hospital Outpatient Administered Injectables - Injectable medications that may be given in a variety of settings but must be given by a healthcare professional. The majority of these drugs are considered to be a medical benefit with coverage at the deductible and coinsurance level.

Copay (also known as Copayment) - The specified charge (flat dollar amount and/or percentage) that the Member is required to pay for a Prescription Medication Product.

Covered Drugs - The following types of medications are covered unless subject to an exception listed under "Excluded Drugs and Supplies:"

1. Federal Legend Drugs: any medicinal substance which bears the legend, "Caution: Federal Law prohibits dispensing without a prescription," except for those medicinal substances classified as exempt narcotics pursuant to State law;
2. An injectable medication can be prescribed to either be self-administered or administered by a healthcare professional. Covered injectable medications include insulin. Refer to the Injectable Medication Listing in this book for additional covered medications.
3. State Restricted Drugs: any medicinal substance which may only be dispensed with a prescription according to State law;
4. Compound Medications: any medicinal substance which must be mixed, compounded, or otherwise prepared by a registered pharmacist and has at least one ingredient that is a Federal legend or State restricted medications in a therapeutic quantity. Claims must be submitted electronically from the pharmacy for coverage consideration. Refer to the compound section on *Drug Exclusion List* to see Certificate of Insurance exclusions;
5. Copayment Amounts do not apply to the following nonprescription diabetes supplies: syringes, lancets, blood glucose test strips, urine test products and control solutions. Prescription Medications and nonprescription diabetes supplies are subject to a dispensing limit of a 100-day supply.

Formulary - The 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. Selection criteria include clinical efficacy, safety, and cost effectiveness.

Generic Medications - Medications that (1) are approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the Brand Name Medication, (2) contain the same active ingredient as the Brand Name Medication, and (3) cost less than the Brand Name equivalent.

Injectable Medication Program – A program designed to meet a member's injectable and other specialty medication needs.

Medical Benefit - Refers to medications which are covered at the deductible/coinsurance level instead of with a copay.

Medication Exclusion - Sanford Health Plan reserves the right to maintain a listing of medications which are specifically not covered under benefit packages per Plan Certificate of Insurance. Payment for the medications on this list will be the Member's responsibility in full. Members may request a review of an adverse determination based on issues of medical necessity as it relates to non-covered medications, generic substitution, therapeutic interchanges and step-therapy protocols. Refer to *Drug Exclusion List* above and the *Complaints and Appeals Procedure* in the Member's Certificate of Insurance.

Member - The Subscriber and, if another Class of Coverage is in force, the Subscriber's Eligible Dependents.

Non-Participating Pharmacy - A pharmacy that does not have a contract with Express Scripts Inc., on behalf of Sanford Health Plan. **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 to 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.**

Over-the-Counter (OTC) Medication - A medication that does not require a prescription order under Federal or State law. Sanford Health Plan does not cover any medications that can be obtained over-the-counter.

Participating Pharmacy - A pharmacy that has contracted with Express Scripts Inc., on behalf of the Plan to deliver prescription medication services to Members. The Participating Pharmacy may be a hospital, pharmacy or other facility that has contractually accepted the terms and conditions set forth by the Health Plan. Refer to the Participating Pharmacy Listing or Express Scripts website found on www.sanfordhealthplan.com/memberlogin. **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 to 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.**

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 Medication Product - A medication, product or device approved by the Food and Drug Administration (FDA) and dispensed under Federal or State law only, pursuant to a prescription order or refill.

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.

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.

Self-Injectable - Self-administered injectable medications can be given at home by the patient or caregiver. Typically these medications are covered under the pharmacy benefit.

Specialty Medications - Specialty medications are defined as injectable and non-injectable medications that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes.
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals.
- Limited or exclusive product availability and distribution.
- Specialized product handling and/or administration requirements.
- Cost in excess of $500 for a 34-day supply

Step Therapy Program - Program using protocols that specify the order in which different medications for a given condition are prescribed. If a Member does not obtain the desired clinical effect or experiences side effects at one step, then the medication choice at another step may be tried. Step therapy requires the use of first-line alternatives before more expensive second-line medications are covered by the pharmacy benefit.

Supply and Dispensing limitations - One (1) Copayment Amount, plus any applicable coinsurance amount, applies per Prescription Order or refill for a 1-34 day supply. Two (2) Copayment Amounts, plus any applicable coinsurance amounts, apply per Prescription Order or refill for 35-100 day supply. Prescription Medications and nonprescription diabetes supplies are subject to a dispensing limit of a 100-day supply.

Formulary

for NDPERS grandfathered members

The following is a list of the most commonly prescribed medications. It represents an abbreviated version of the medication formulary that is the core of your pharmacy benefit coverage. In addition to using this list, allowing substitution of generic products is encouraged when appropriate.

NOTE: Generic medications are shown in lower-case and *italicized*. Brand name medications are listed in CAPITAL letters. Benefits are not limited to the medications on this formulary list. Products not listed in this formulary may be non-formulary, if you cannot find the medication that you are looking for or have questions, please contact the Plan at (888) 315-0885.

This is NOT a complete listing of covered medications. For a complete list, you can go to www.sanfordhealthplan.com/memberlogin and link to the Express Scripts website.

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Abbreviations

PA: Prior Authorization. The Plan requires you or your physician to get prior authorization for certain medications. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, we may not cover the drug.

QL: Quantity Limit. For certain medications, the Plan limits the amount of the medication that we will cover.

SP: Specialty medications are defined as injectable and non-injectable medications that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and intensive clinical monitoring to decrease the potential for drug toxicity and increase the probability for beneficial treatment outcomes.
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals.
- Limited or exclusive product availability and distribution.
- Specialized product handling and/or administration requirements.
- Cost in excess of $500 for a 34-day supply

ST: Step Therapy. Program using protocols that specify the order in which different medications for a given condition are prescribed. If a Member does not obtain the desired clinical effect or experiences side effects at one step, then the medication choice at another step may be tried. Step therapy requires the use of first-line alternatives before more expensive second-line medications are covered by the pharmacy benefit.

Medication Name	PA/Step/QL/SP
Anti-Infectives	
Antifungal Agents	
clotrimazole	
CRESEMBA	
fluconazole	
griseofulvin microsize	
itraconazole	
ketoconazole	
nystatin	
terbinafine hcl	
voriconazole	
Antivirals	
abacavir	
abacavir-lamivudine-zidovudine	
acyclovir	
adefovir	
amantadine hcl	
ATRIPLA	
COMPLERA	
EDURANT	
EMTRIVA	
EPZICOM	
EVOTAZ	
famciclovir	
HARVONI	PA
INTELENCE	
ISENTRESS	
KALETRA	
lamivudine	
lamivudine-zidovudine	
LEXIVA	
nevirapine	
NORVIR	
OLYSIO	PA; SP
PREZCOBIX	
PREZISTA	
REYATAZ	
ribapak dose pack, ribasphere,	SP
ribavirin	SP
SELZENTRY	
SOVALDI	PA; SP

Medication Name	PA/Step/QL/SP
STRIBILD	
SUSTIVA	
TAMIFLU	
TIVICAY	
TRUVADA	
valacyclovir	
valganciclovir hcl	
VIEKIRA PAK	SP; PA
VIRACEPT	
VIRAMUNE XR	
VIREAD	
VITEKTA	
zidovudine	
Cephalosporins	
cefaclor	
cefadroxil	
cefdinir	
cefixime	
cefpodoxime	
cefprozil	
CEFTIN	
cefuroxime axetil	
cephalexin	
Erythromycins & Other Macrolides	
azithromycin	
clarithromycin	
DIFICID	
E.E.S. GRANULES	
ery-tab	
ERYPED 200	
erythromycin	
Miscellaneous Antiinfectives	
ALBENZA	
atovaquone	
atovaquone-proguanil	
CAYSTON	SP
chloroquine phosphate	
clindamycin	
DAPSONE	
ethambutol	
hydroxychloroquine	

PA = medication requires prior authorization. ST = medication requires step therapy. QL = medication has restrictions on the quantity that can be obtained. SP = medication must obtained at specific network specialty pharmacies.

Medication Name	PA/Step/QL/SP
isoniazid	
ivermectin	
mefloquine	
metronidazole	
neomycin	
quinine sulfate	
rifampin	
tinidazole	
XIFAXAN	
ZYVOX	PA
Penicillins	
amoxicillin	
amoxicillin-pot clavulanate	
ampicillin	
dicloxacillin	
penicillin v potassium	
Quinolones	
AVELOX ABC PACK	
ciprofloxacin hcl	
levofloxacin	
moxifloxacin	
Sulfa's & Related Agents	
sulfamethoxazole-trimethoprim	
Tetracyclines	
DORYX	
doxycycline hyclate, -monohydrate	
minocycline	
tetracycline	
VIBRAMYCIN	
Urinary Tract Agents	
MACRODANTIN	
methenamine hippurate, -mandelate	
MONUROL	
nitrofurantoin	
trimethoprim	
Vancomycin	
vancomycin	
Antineoplastic & Immunosuppressant Drugs	
Adjunctive Agents	
leucovorin calcium	
Antineoplastic & Immunosuppressant Drugs	

Medication Name	PA/Step/QL/SP
anastrozole	
azathioprine	
bicalutamide	
cyclophosphamide	
cyclosporine	
exemestane	
flutamide	
gengraf	
hydroxyurea	
IMBRUVICA	
letrozole	
MEGACE ES	
megestrol	
mercaptopurine	
methotrexate sodium	
mycophenolate mofetil	
RAPAMUNE	
SOMATULINE DEPOT	PA; SP
tacrolimus	
tamoxifen	
Autonomic & CNS Drugs, Neurology & Psych	
Anticonvulsants	
BANZEL	
carbamazepine	
clonazepam	
diazepam	
divalproex	
epitol	
ethosuximide	
felbamate	
gabapentin	
GRALISE	
lamotrigine, -odt	
levetiracetam	
LYRICA	
ONFI	
oxcarbazepine	
phenobarbital	
phenytoin/extended release	
POTIGA	
primidone	

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Medication Name	PA/Step/QL/SP
TEGRETOL XR	
tiagabine	
topiramate	
TROKENDI XR	
valproic acid	
VIMPAT	
zonisamide	
Antiparkinsonism Agents	
AZILECT	
benztropine	
bromocriptine	
carbidopa-levodopa	
carbidopa-levodopa-entacapone	
entacapone	
NEUPRO	
pramipexole, -er	
ropinirole	
RYTARY ER	
selegiline hcl	
trihexyphenidyl	
Migraine & Cluster Headache Therapy	
AXERT	QL – Limit 6/Rx
FROVA	QL – Limit 9/Rx
isometh-dichloral-acetaminophn	
naratriptan	QL – Limit 9/Rx
RELPAX	QL – Limit 12/Rx
rizatriptan	QL – Limit 12/Rx
sumatriptan tablets	QL – Limit 12/Rx
sumatriptan injections	QL – Limit 1kit/Rx
sumatriptan nasal spray	QL – Limit 6/Rx
zolmitriptan	QL – Limit 12/Rx
Miscellaneous Neurological Therapy	
AMPYRA	PA; SP
AUBAGIO	PA; SP
COPAXONE	PA; SP
donepezil	
EXELON	
galantamine	
GILENYA	PA; SP
HORIZANT	

Medication Name	PA/Step/QL/SP
NAMENDA	
NAMENDA XR	
NAMZARIC	
NUEDEXTA	
rivastigmine	
TECFIDERA	PA; SP
Muscle Relaxants & Antispasmodic Therapy	
baclofen	
carisoprodol	
chlorzoxazone	
cyclobenzaprine	
dantrolene	
MESTINON TIMESPAN	
metaxalone	
methocarbamol	
orphenadrine citrate	
pyridostigmine bromide	
tizanidine	
Narcotic Analgesics	
ABSTRAL	
acetaminophen-codeine	
ascomp with codeine	
BUPAP	
buprenorphine hcl	
butalbital compound w/codeine	
butalbital-acetaminop-caf-cod	
butalbital-acetaminophen	
butalbital-acetaminophen-caff	
butalbital-aspirin-caffeine	
BUTRANS	
endocet	
fentanyl patches	
FENTORA	
hydrocodone-acetaminophen	
hydrocodone-ibuprofen	
HYSINGLA ER	
ONSOLIS	SP
oxycodone	
oxycodone-acetaminophen	
oxycodone-aspirin	
OXYCONTIN	

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Medication Name	PA/Step/QL/SP
oxymorphone	
reprexain	
ROXICET	
vicodin/es/hp	
zamicet	
Non-Narcotic Analgesics	
buprenorphine-naloxone	
butorphanol tartrate	
celecoxib	
diclofenac sodium	
diclofenac-misoprostol	
diflunisal	
etodolac	
FLECTOR	
flurbiprofen	
ibuprofen	
indomethacin	
ketoprofen	
ketorolac	
mefenamic acid	
meloxicam	
nabumetone	
naltrexone	
NAPRELAN CR	
naproxen	
NUCYNTA	
oxaprozin	
pentazocine-naloxone	
piroxicam	
salsalate	
SUBOXONE	
sulindac	
tramadol	
tramadol-acetaminophen	
VIMOVO	
VOLTAREN GEL	
Psychotherapeutic Drugs	
alprazolam	
amitriptyline	
amitriptyline-chlordiazepoxide	
amphetamine salt combo	

Medication Name	PA/Step/QL/SP
aripiprazole	
bupropion hcl	
buspirone	
chlordiazepoxide hcl	
chlorpromazine	
citalopram	
clomipramine	
clonidine hcl	
clorazepate dipotassium	
clozapine	
DAYTRANA	
desipramine	
DESVENLAFAXINE	ST
dexmethylphenidate, -hcl er	
dextroamphetamine	
diazepam	
doxepin	
duloxetine	
escitalopram oxalate	
estazolam	
eszopiclone	
fluoxetine	
fluphenazine hcl	
flurazepam	
fluvoxamine	
haloperidol	
imipramine hcl	
KAPVAY	
LATUDA	
lithium carbonate	
lorazepam	
lorazepam intensol	
loxapine succinate	
methylphenidate	
mirtazapine	
modafinil	
nefazodone	
nortriptyline	
NUVIGIL	
olanzapine	
olanzapine-fluoxetine	

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Medication Name	PA/Step/QL/SP
ORAP	
oxazepam	
paroxetine hcl	
perphenazine	
perphenazine-amitriptyline	
phenelzine	
PRISTIQ	ST
protriptyline	
quetiapine	
QUILLIVANT XR	
risperidone	
RITALIN LA	
SEROQUEL XR	
sertraline	
STRATTERA	
temazepam	
thioridazine	
thiothixene	
tranylcypromine	
trazodone	
triazolam	
trifluoperazine	
venlafaxine	
VIIBRYD	ST
VYVANSE	
XYREM	SP
zaleplon	
ziprasidone hcl	
zolpidem	
Cardiovascular, Hypertension & Lipids	
Antiarrhythmic Agents	
amiodarone	
flecainide	
mexiletine	
MULTAQ	
pacerone	
propafenone	
sotalol	
SOTYLIZE	PA
TIKOSYN	
Antihypertensive Therapy	

Medication Name	PA/Step/QL/SP
acebutolol	
afeditab cr	
amiloride, -hctz	
amlodipine, -hctz,	
amlodipine-valsarta-hctz,	
AMTURNIDE	
atenolol, -chlorthalidone	
benazepril, -hctz	
betaxolol	
BIDIL	
bisoprolol, -hctz	
bumetanide	
BYSTOLIC	
candesartan, -hctz	
captopril	
cartia xt	
carvedilol	
chlorothiazide	
chlorthalidone	
clonidine	
COREG CR	
dilt-xr	
diltiazem hcl	
DIURIL	
doxazosin	
enalapril, -hctz	
eplerenone	
felodipine	
fosinopril, -hctz	
furosemide	
guanfacine, -hcl er	
hydralazine	
hydrochlorothiazide (hctz)	
indapamide	
irbesartan, -hctz	
labetalol	
lisinopril, - hctz	
losartan, hctz	
matzim la	
methyldopa	
metolazone	

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Medication Name	PA/Step/QL/SP
metoprolol, -hctz	
metoprolol tartrate	
minoxidil	
moexipril, -hctz	
nadolol	
nifedical xl	
nifedipine	
nisoldipine	
perindopril erbumine	
pindolol	
prazosin	
propranolol	
quinapril, -hctz	
ramipril	
spironolactone, -hctz	
taztia xt	
TEKAMLO	
TEKTURNA, -HCTZ	
telmisartan, -hctz	
terazosin	
timolol maleate	
torsemide	
trandolapril, -verapamil	
triamterene-hydrochlorothiazid	
valsartan, -hctz	
verapamil	
Cardiac Glycosides	
digox	
digoxin	
Coagulation Therapy	
AGGRENOX	
BRILINTA	
cilostazol	
clopidogrel	
dipyridamole	
EFFIENT	
enoxaparin	
fondaparinux	
FRAGMIN	
jantoven	
MEPHYTON	

Medication Name	PA/Step/QL/SP
pentoxifylline	
PRADAXA	
ticlopidine	
warfarin	
XARELTO	
Lipid/Cholesterol Lowering Agents	
ADVICOR	
amlodipine-atorvastatin	
atorvastatin	
cholestyramine	
colestipol	
CRESTOR	ST
fenofibrate	
fluvastatin	
gemfibrozil	
LIPTRUZET	ST
lovastatin	
LOVAZA	PA
niacin	
omega-3 acid ethyl esters	
pravastatin	
prevalite	
simvastatin	
WELCHOL	
ZETIA	ST
Miscellaneous Cardiovascular Agents	
CORLANOR	
RANEXA	
Nitrates	
isosorbide dinitrate	
isosorbide mononitrate	
nitro-bid	
nitroglycerin	
NITROSTAT	
Dermatologicals/Topical Therapy	
Antipsoriatic / Antiseborrheic	
acitretin	
calcipotriene	
calcipotriene-betamethasone	
PRAMOSONE	
selenium sulfide	

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Medication Name	PA/Step/QL/SP
SORILUX	
STELARA	PA; SP
sulfacetamide sodium	
TACLONEX	
Burn Therapy	
silver sulfadiazine	
Keratolytics	
salicylic acid	
Miscellaneous Dermatologicals	
CARAC	
CONDYLOX	
diclofenac sodium	
ELIDEL	
fluorouracil	
imiquimod	
podofilox	
tacrolimus	
urea	
x-viate	
ZYCLARA	
Therapy For Acne	
ACANYA	
adapalene	
AZELEX	
BENZACLIN PUMP	
clindamycin phosphate	
clindamycin-benzoyl peroxide	
DIFFERIN	
EPIDUO	
ery pads	
erythromycin-benzoyl peroxide	
FINACEA/PLUS	
metronidazole	
MIRVASO	
myorisan	
Sodium sulfacetamide/sulfur	
sulfacetamide sod-sulfur-urea	
sulfacetamide sodium-sulfur	
TAZORAC	
tretinoin	Age >30 OR Derm only

Medication Name	PA/Step/QL/SP
zenatane	
Topical Anesthetics	
lidocaine	
lidocaine hcl	
Topical Antibacterials	
ALTABAX	
gentamicin	
mupirocin	
sulfacetamide sodium	
Topical Antifungals	
ciclopirox	
clotrimazole-betamethasone	
econazole	
ERTACZO	
EXELDERM	
ketoconazole	
nyamyc	
nystatin	
nystatin-triamcinolone	
nystop	
OXISTAT	
Topical Antivirals	
acyclovir	
DENAVIR	
XERESE	
ZOVIRAX	
Topical Corticosteroids	
alclometasone	
betamethasone,- dipropionate, -valerate	
clobetasol, -proprionate	
clobetasol-emollient	
desonide	
desoximetasone	
diflorasone	
fluocinolone	
fluocinonide	
fluticasone	
halobetasol propionate	
HALOG	
hydrocortisone, -butyrate, -valerate	
LOCOID	

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Medication Name	PA/Step/QL/SP
mometasone	
TOPICORT	
triamcinolone acetonide	
ULTRAVATE PAC	
Topical Scabicides / Pediculicides	
EURAX	
malathion	
permethrin	
SKLICE	
spinosad	
ULESFIA	
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Miscellaneous Agents	
acamprosate	
anagrelide	
cevimeline	
disulfiram	
FOSRENOL	
midodrine	
pilocarpine hcl	
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sevelamer carbonate	
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azelastine	
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ipratropium bromide nasal	
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Miscellaneous Otic Preparations	
antipyrine-benzocaine	
ciprofloxacin hcl	
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ofloxacin	
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CORTISPORIN-TC	
neomycin-polymyxin-hc	
Endocrine/Diabetes	
Adrenal Hormones	

Medication Name	PA/Step/QL/SP
dexamethasone	
fludrocortisone	
hydrocortisone	
methylprednisolone	
prednisolone, -odt	
prednisone	
veripred 20	
Antithyroid Agents	
methimazole	
propylthiouracil	
Diabetes & Supplies	
acarbose	
ACTOPLUS MET XR	
BYDUREON	ST
BYETTA	ST
CYCLOSET	
FARXIGA	
glimepiride	
glipizide	
glipizide-metformin	
GLUCAGEN HYPOKIT	
GLUCAGON EMERGENCY KIT (HUMAN)	
glyburide	
glyburide micronized	
glyburide-metformin	
GLYXAMBI	PA
INVOKANA	
JANUMET/XR	
JANUVIA	
KOMBIGLYZE XR	
LANTUS VIAL	
LANTUS SOLOSTAR	
LEVEMIR VIAL	
LEVEMIR FLEXPEN/FLEXTOUCH	
metformin	
nateglinide	
NOVOLIN 70/30, -N, -R VIALS	
NOVOLOG VIALS	
NOVOLOG FLEXPEN	
NOVOLOG MIX 70-30 VIAL	
NOVOLOG MIX 70-30 FLEXPEN	

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Medication Name	PA/Step/QL/SP
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ONE TOUCH TEST STRIP	
ONGLYZA	
pioglitazone	
pioglitazone-metformin	
repaglinide	
RIOMET	
SYMLINPEN	PA
TRULICITY	ST
VICTOZA	ST
Miscellaneous Hormones	
ANDRODERM	PA
ANDROGEL	PA
AXIRON	PA
BRAVELLE	
cabergoline	
calcitonin (salmon)	
calcitriol	
CETROTIDE	
chorionic gonadotropin 10000 un vial	
clomiphene citrate	
desmopressin	
FOLLISTIM AQ	
fortical	
GANRELIX ACETATE	
GONAL – F, - RFF, - RFF REDI JECT	
MENOPUR	
OVIDREL	
REPRONEX	
SENSIPAR	
testosterone cypionate	PA
Thyroid Hormones	
ARMOUR THYROID	
levothyroxine	
levoxyl	
liothyronine	
unithroid	
Gastroenterology	
Antidiarrheals & Antispasmodics	
chlordiazepoxide-clidinium	
dicyclomine	

Medication Name	PA/Step/QL/SP
diphenoxylate-atropine	
glycopyrrolate	
hyoscyamine sulfate	
methscopolamine	
Miscellaneous Gastrointestinal Agents	
alophen	
AMITIZA	
ASACOL, -HD	
balsalazide	
budesonide	
CANASA	
CIMZIA	PA; SP
compro	
constulose	
CORTIFOAM	
CREON	
cromolyn	
DELZICOL	
DICLEGIS	
dronabinol	
dulcolax balance	
EMEND	QL – Limit 3/Rx
enulose	
fleet laxative	
Gavilyte, --h and bisacodyl	
GOLYTELY	
granisetron hcl	QL – Limit 2/Rx
hydrocortisone-pramoxine	
KRISTALOSE	
lactulose	
LIALDA	
LINZESS	
meclizine	
mesalamine	
metoclopramide hcl, -odt	
MOVANTIK	
ondansetron	
PANCREAZE	
pancrelipase 5000	
peg 3350-electrolytes	
peg-3350 with flavor packs	

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Medication Name	PA/Step/QL/SP
PENTASA	
prochlorperazine	
PROCTOFOAM HC	
proctosol hc	
proctozone-hc	
sulfasalazine	
sulfazine	
TRANSDERM-SCOP	
trilyte with flavor packets	
trimethobenzamide	
ULTRESA	
ursodiol	
ZENPEP	
Ulcer Therapy	
amoxicil-clarithromy-lansopraz	
carafate	
cimetidine	
esomeprazole	
famotidine	
first- lansoprazole	
first- omeprazole	
misoprostol	
omeprazole	
pantoprazole	
rabeprazole	
sucralfate	
Immunology, Vaccines & Biotechnology	
Biotechnology Drugs	
ARANESP	SP
AVONEX	
EXTAVIA	PA; SP
HUMATROPE	PA; SP
NEULASTA	SP
NEUPOGEN	SP
NUTROPIN, -AQ, -NUSPIN	PA; SP
PEGASYS, -PROCLICK	PA; SP
PEGINTRON, -REDIPEN	PA; SP
PLEGRIDY	PA; SP
PROCRIT	SP
REBIF, -REBIDOSE	PA; SP
Musculoskeletal & Rheumatology	

Medication Name	PA/Step/QL/SP
Gout Therapy	
allopurinol	
colchicine-probenecid	
COLCRYS	
probenecid	
ULORIC	PA
Osteoporosis Therapy	
ACTONEL	
alendronate	
FORTEO	PA; SP
ibandronate	
raloxifene	
risedronate	
Other Rheumatologicals	
ACTEMRA SC	PA; SP
ENBREL, - SURECLICK	PA; SP
HUMIRA, -PEN	PA; SP
leflunomide	
ORENCIA	PA; SP
OTEZLA	PA; SP
SAVELLA	
SIMPONI	PA; SP
XELJANZ	PA; SP
Obstetrics & Gynecology	
Estrogens & Progestins	
COMBIPATCH	
covaryx	
CRINONE	
DIVIGEL	
eemt	
ELESTRIN	
ENDOMETRIN	
ESTRACE	
estradiol oral and patch	
estradiol-norethindrone acet	
ESTRING	
ESTROGEL	
estrogens-methyltestosterone	
estropipate	
EVAMIST	
FEMHRT LOW DOSE	

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Medication Name	PA/Step/QL/SP
FEMRING	
PREMARIN	
PREMPHASE	
PREMPRO	
progesterone micronized	
VAGIFEM	
Miscellaneous Ob/Gyn	
CLEOCIN VAG SUPPOSITORY	
clindamycin phosphate vaginal cream	
CLINDESSE	
metronidazole	
OSPHENA	
terconazole vaginal cream, -suppository	
tranexamic acid	
vandazole	
Oxytocics	
methylergonovine	
Ophthalmology	
Antibiotics	
AZASITE	
bacitracin	
bacitracin-polymyxin b	
CILOXAN	
ciprofloxacin hcl	
erythromycin	
gatifloxacin	
gentak	
gentamicin	
neomycin-polymyxin-gramicidin	
ofloxacin	
polymyxin b sulf-trimethoprim	
tobramycin	
TOBREX	
VIGAMOX	
Antivirals	
trifluridine	
ZIRGAN	
Beta-Blockers	
betaxolol	
BETIMOL	
BETOPTIC S	

Medication Name	PA/Step/QL/SP
carteolol	
ISTALOL	
levobunolol	
timolol maleate	
TIMOPTIC OCUDOSE (PF)	
Cycloplegic Mydriatics	
atropine	
cyclopentolate	
Direct Acting Miotics	
pilocarpine hcl	
Miscellaneous Ophthalmologics	
azelastine	
cromolyn	
epinastine	
PATADAY	
PATANOL	
RESTASIS	
Non-Steroidal Anti-Inflammatory Agents	
ACUVAIL	
bromfenac	
diclofenac sodium	
flurbiprofen sodium	
ketorolac	
Oral Drugs For Glaucoma	
acetazolamide	
methazolamide	
Other Glaucoma Drugs	
AZOPT	
COMBIGAN	
COSOPT	
dorzolamide	
dorzolamide-timolol	
latanoprost	
LUMIGAN	PA
RESCULA	
SIMBRINZA	
travoprost (benzalkonium)	
Steroid-Antibiotic Combinations	
neomycin-polymyxin b-dexameth	
neomycin-polymyxin-hc	
TOBRADEX	

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Medication Name	PA/Step/QL/SP
tobramycin-dexamethasone	
ZYLET	
Steroids	
dexamethasone sodium phosphate	
fluorometholone	
FML S.O.P.	
LOTEMAX	
PRED MILD	
prednisolone acetate	
Steroid-Sulfonamide Combinations	
BLEPHAMIDE	
sulfacetamide-prednisolone	
Sulfonamides	
sulfacetamide sodium	
Sympathomimetics	
ALPHAGAN P	
brimonidine	
Respiratory, Allergy, Cough & Cold	
Antihistamine & Antiallergenic Agents	
arbinoxa	
AUVI-Q	
carbinoxamine maleate	
cetirizine	
cyproheptadine	
epinephrine	
EPIPEN 2-PAK	
EPIPEN JR 2-PAK	
hydroxyzine hcl	
promethazine	
promethegan	
Cough & Cold Therapy	
benzonatate	
BROMFED DM	
chlorpheniramine-hydrocodone	
cpm-pseudoephed-hydrocodone	
hydrocodone-homatropine	
hydromet	
promethazine, - vc, -codeine, -dm,	
Pulmonary Agents	
acetylcysteine	
ADCIRCA	SP

Medication Name	PA/Step/QL/SP
ADVAIR DISKUS, -HFA	
albuterol sulfate	
ARCAPTA NEOHALER	
ATROVENT HFA	
BREO ELLIPTA	
budesonide	
COMBIVENT, -RESPIMAT	
DALIRESP	
DYMISTA	
FLOVENT DISKUS, -HFA	
flunisolide	
fluticasone	
FORADIL AEROLIZER	
ipratropium bromide	
ipratropium-albuterol	
LETAIRIS	PA; SP
levalbuterol hcl	
montelukast	
NASONEX	
PERFOROMIST	
PROAIR HFA	
PULMICORT	
PULMICORT FLEXHALER	
PULMOZYME	SP
QVAR	
SEREVENT DISKUS	
SPIRIVA	
SYMBICORT	
THEO-24	
theophylline	
TRACLEER	PA; SP
triamcinolone acetonide	
TUDORZA PRESSAIR	
VENTOLIN HFA	
zafirlukast	
ZYFLO CR	
Urologicals	
Anticholinergics & Antispasmodics	
flavoxate	
oxybutynin chloride	
tolterodine	

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Medication Name	PA/Step/QL/SP
TOVIAZ	
trospium	
VESICARE	
Benign Prostatic Hyperplasia (BPH) Therapy	
alfuzosin	
AVODART	
finasteride	
JALYN	
tamsulosin	
Cholinergic Stimulants	
bethanechol chloride	
Miscellaneous Urologicals	
cytra-k	
ELMIRON	
potassium citrate	
URELLE	
URIBEL	
VIAGRA	QL – Limit 18 tabs/90 days
Urinary Anesthetics	
phenazopyridine	
Vitamins, Hematinics & Electrolytes	
Electrolytes	
eliphos	
klor-con	
oyster shell calcium-vit d3	
PHOSLYRA	
phospha 250 neutral	
potassium chloride	
Vitamins & Hematinics	
b complex-vitamin c-folic acid	
folic acid	
one daily prenatal	
prenatal complete	
prenatal multivitamins	

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PA = medication requires prior authorization. ST = medication requires step therapy. QL = medication has restrictions on the quantity that can be obtained. SP = medication must obtained at specific network specialty pharmacies.

NDPERS Member Handbook

North Dakota Public Employees Retirement System
Dakota Plan Health Benefits

SANFORD HEALTH PLAN

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Dear Sanford Health Plan NDPERS Member,

We are pleased to have you as a Member and welcome you to our care system! This booklet will help you get to know your benefits. It is made up of tips on how you can reach us, how to use your benefits and how to find Participating Providers [Doctors and hospitals that contract with Sanford Health Plan]. We look forward to serving you.

Introduction

This Member Handbook is not a contract. This Handbook is designed to give you the basic facts needed as a Member. It will also serve as a guide when seeking health care services. Your Certificate of Insurance (COI) and the NDPERS Service Agreement are the formal benefit plan documents for the employee welfare benefit plan set up by NDPERS.

For details about your coverage, please see your COI, which gives all of the terms and conditions of enrollment.

Note: *This Plan may not cover all your health care costs. Read your COI with care to find out which costs are covered.*

How to Contact Us

If you have more questions after reading the Handbook or your COI, or need any help, we are open between the hours of 8 a.m. to 5:30 p.m. Central Time, Monday through Friday.

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

Privacy Practices

Our Privacy policies may be found at www.sanfordhealthplan.com/ndpers in the Privacy of Health Information link at the bottom of the page:

- Notice of Privacy Practices
- Confidentiality and Disclosure of Personal Health Information
- Protection of Oral, Written and Electronic Information across Sanford Health Plan

Member Rights & Responsibilities

Member Rights

We are committed to treating you in a way that respects your rights. Each Member (or the Member's parent, legal guardian, or other responsible person, if the Member is a minor or not able to make choices on their own) has the right to the following:

1. You have the right to get access to health care and/or services that are ready 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 substance use disorder; disability; religious beliefs; or sources of payment for care.
2. You have the right to considerate, respectful treatment always, and under all circumstances, with recognition of your personal dignity.
3. You have the right to be questioned and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. You have the right, but are not required, to select a Primary Care Doctor of your choice. If you are not happy for any reason with the main doctor initially chosen, you have the right to choose another doctor.
5. You have the right to expect communications and other records about your care, along with the source of payment for treatment, to be treated as confidential, in line with the guidelines set up in applicable North Dakota law.
6. You have the right to know who someone is and professional status of people supplying services to you, and to know which Doctor and/or Provider is mainly responsible for your care. You also have the right to get information about our clinical guidelines and rules.
7. You have the right to a honest talk with the Doctors and/or Providers responsible for coordinating appropriate or medically necessary treatment choices for your conditions in a way that is clear, regardless of cost or benefit coverage for

those treatment choices. You also have the right to join with Doctors and/or Providers in decision making about your treatment plan.
8. You have the right to give informed consent before the start of any procedure or treatment.
9. When you do not speak or understand the main language of the community, we will make reasonable efforts to access an interpreter. We have the duty to make reasonable efforts to access a treatment clinician that is able to communicate with you.
10. You have the right to get printed materials that describe important information about us in a format that is easy to understand and easy to read.
11. You have the right to a clear Grievance and Appeal process for complaints and comments and to have your issues resolved in a timely way.
12. You have the right to Appeal any decision on medical necessity made by us and our Doctors and/or Providers.
13. You have the right to end coverage, in line with NDPERS and/or Plan guidelines.
14. You have the right to make recommendations about the organization's Members' rights and responsibilities policies.
15. You have the right to get information about the organization, its services, its Doctors 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 not able to make choices on their own) is responsible for cooperating with those supplying Health Care Services to you, and shall have the following responsibilities:

1. You have the responsibility to give, to the best of your knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, drugs, and other matters about your health. You have the responsibility to tell your Doctor about unexpected changes in your condition. You are responsible for speaking up if you do not understand a planned course of action and what your role is.
2. You are responsible for carrying your Plan ID cards with you and for having your identification numbers on hand when telephoning or talking with us.
3. You are responsible for following all access and availability procedures.
4. You are responsible for seeking Emergency care at a Plan participating Emergency Facility when possible. If 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. You are responsible for telling us of an Emergency admission as soon as reasonably possible and no later than forty-eight (48) hours after being physically or mentally able to give notice.
6. You are responsible for keeping appointments and, when you are not able to do so for any reason, for telling the responsible Doctor or the Hospital.
7. You are responsible for following your treatment plan as told by the Doctor mainly responsible for your care. You are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding your health conditions, including mental health and/or substance use disorders.
8. You are responsible for your actions if you say no to treatment or do not follow the Doctor's orders.
9. You are responsible for telling NDPERS within *thirty-one (31)* days if you change your name, address, or phone number.
10. You are responsible for telling NDPERS of any changes of eligibility that may affect your membership or access to services.

Member Services Department

We believe that good service depends on good communication with you. We encourage you to contact Member Services for help when you need it by calling (800) 499-3416 *(toll-free)* | TTY/TDD: (877) 652-1844 *(toll-free)* or emailing memberservices@sanfordhealth.org. We are happy to help you with questions about:

- How claims are paid
- Where to find a doctor or facility in your area
- If you have a complaint
- Getting another ID card

We are open and can answer your questions from 8 a.m. to 5:30 p.m. Central Time, Monday through Friday.

Eligibility of Dependents

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

Spouse - Your spouse, who is a person of the opposite sex, is always eligible for coverage, subject to the eligibility requirements of 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

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b. incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the you for support and maintenance. If we ask, you must give proof of your child's disability within *thirty-one (31)* days of our request; or
c. Your grandchild(ren) or those of the your living, covered Spouse, who legally live with you; given that (1) the parent of the grandchild(ren) is also covered as your Dependent; and (2) both the parent (Covered Dependent) and child of such Dependent (grandchild) are chiefly dependent upon you for support.

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 deciding 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.

Newborn Coverage

If you have Family Coverage, you are encouraged to tell us when you are pregnant and know your due date. If you have a child through birth, your newborn child will become covered from the date of their birth. Newborn children will be added to a policy automatically if you are enrolled in Family Coverage and we are told of the pregnancy.

If you have Single Coverage, you must apply for Family Coverage with NDPERS within thirty-one (31) days from the newborn's date of birth.

Special Communication Services

Please call us 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.

In compliance with the ADA, we have this document in other formats. If you need help, please contact the NDPERS ADA Coordinator at (701) 328-3900.

Translation Services

We can arrange for translation services. Free written materials are available in many different languages and free oral translation services are available. Call Member Services 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)*.

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

If you are deaf or hearing impaired and need to speak to us, call TTY/TDD: (877) 652-1844 *(toll-free)*. Please contact us 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.

Member Benefits

As a Plan Member, your benefits package is one of the most comprehensive available today. Basic primary care and preventive benefits are available through your Primary Care Doctor or other Participating Providers. Please see your Summary of Benefits & Coverage and your Certificate of Insurance for a description of covered services, as well as those that are not covered.

Formulary

Sanford Health Plan covers prescribed medications according to our Formulary. A formulary is a list of Prescription Drug Products, which we are prefer for dispensing to you when needed. This list is subject to periodic review and modifications. Additional medications may be added or removed from the Formulary throughout the year. We will notify you of any Formulary changes. For a copy of our Formulary, contact Pharmacy Management at (888) 315-0885 | TTY/TDD: (877) 652-1844, or visit your account at www.sanfordhealthplan.com/memberlogin.

For More Detailed Pharmacy Information

Please see the following documents for specific drug coverage information. You may also contact Pharmacy Management for this information or find it on your account at www.sanfordhealthplan.com/memberlogin.

1. **Summary of Benefits & Coverage (SBC)** – describes the payments for which you are responsible when purchasing prescription drugs and supplies.
2. **Summary of Pharmacy Benefits** – describes specific information on drug exclusions, drugs that require Preauthorization/Prior Approval, quantity level limits on drugs, our injectable drug program, and the formulary.
3. **Certificate of Insurance (COI)** – describes how and where to get your prescription drugs and supplies, dispensing limitations, and excluded drugs and supplies.

To see the pharmacy locator, health news, drug side effect and interaction information, generic substitution information, personal reminders, benefit information, and your current medications, go to your account at

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www.sanfordhealthplan.com/memberlogin. You will find our Formulary and other pharmacy information as well. You may also click 'Find a Pharmacy' to access the Express Scripts web link.

For information on benefits when you need a prescription medication, and are outside the United States, see your COI.

Emergency and Urgent Care Situations

Emergency Medical Conditions

Emergency services from Basic Plan-level Doctors and Hospitals will be covered at the same benefit and cost sharing level as services supplied by PPO-level Doctors and Hospitals, both within and outside of the Sanford Health Plan Service Area, in cases where a Prudent Layperson reasonably believed that you had an Emergency Medical Condition.

Note: If we determine your condition did not meet Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts will apply, and you are responsible for charges above the Reasonable Cost.

If you have an Emergency Medical Condition, you are encouraged to get services at the nearest Emergency Facility that is a Participating Provider. If the Emergency Medical Condition is so bad that you cannot go safely to the nearest Participating Emergency Facility, then you should go to the nearest Emergency Facility. To find a list of Participating Doctors and Hospitals, visit www.sanfordhealthplan.com/memberlogin or call us toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 *(toll-free)*.

You, or a designated relative or friend must notify us, and your Primary Care Doctor, 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 you are physically or mentally able to do so.

What is an Emergency Medical Condition?

An **Emergency Medical Condition** is the sudden and unexpected start of a health problem 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.

We cover worldwide Emergency services necessary to screen and stabilize you 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 from Doctors and Hospitals outside of the U.S.

Participating Emergency Doctors and Hospitals

We cover Emergency services necessary to screen and stabilize you without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that you had an Emergency Medical Condition.

Note: If we determine your condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts may apply, depending on whether services were received from a PPO-level or Basic-level Participating Provider/Facility, as set forth in Section 1 of your COI.

Non-Participating Emergency Doctors and Hospitals

We cover Emergency services necessary to screen and stabilize you and do not require Prospective (Pre-Service) Review if a Prudent Layperson would have reasonably believed that taking time to get to a Participating Doctor or Hospital would make your emergency worse, or if a provision of federal, state, or local law requires the use of a specific Doctor. Our coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Doctor or Hospital.

Note: If we determine your condition did not meet the Prudent Layperson definition of an Emergency, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Doctors and Hospitals set forth in Section 1, and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 1 in your COI for more information.

If you are admitted as an inpatient to a Non-Participating Hospital or other Facility, then we will contact the admitting Doctor to determine medical necessity and a plan for treatment. In some cases, where it is medically safe to do so, you may be transferred to a Participating Hospital and/or other appropriate Facility.

Urgent Care Situations

Treatment supplied in Urgent Care Situations from Basic Plan-level Doctors and Hospitals will be covered at the same benefit and cost sharing level as services supplied by PPO-level Doctors and Hospitals, both within and outside of the Sanford Health Plan Service Area, in cases where a Prudent Layperson reasonably believed that you were in an Urgent Care Situation.

Note: If we determine your condition did not meet Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, and you are responsible for charges above the Reasonable Cost.

If an **Urgent Care Situation** occurs, you should contact your Primary Care Doctor immediately, if one has been selected, and follow his or her instructions. If a Primary Care Doctor has not been selected, you should contact us and follow our instructions. You may always go directly to any urgent care or after-hours clinic. If possible, you should go to participating provider (call us for a list of Participating Doctors and Hospitals or find it at www.sanfordhealthplan.com/memberlogin).

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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.

An **Urgent Care Request** means that the time span for deciding a non-Urgent Care Request for a health care service or course of treatment:

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

Participating Urgent Care Doctors and Hospitals

We cover services in an Urgent Care Situation without Preauthorization/Prior Approval in cases where a Prudent Layperson reasonably believed that you had an Urgent Care Situation.

Note: If we determine your condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts may apply, depending on whether services were received from a PPO-level or Basic-level Participating Provider/Facility; see Section 1 of your COI for details.

Non-Participating Urgent Care Doctors and Hospitals

We cover services in an Urgent Care Situation without Preauthorization/Prior Approval requirements if a Prudent Layperson would have would have reasonably believed that taking time to get to a Participating Doctor or clinic would make your situation worse, or if a provision of federal, state, or local law requires the use of a specific doctor. Your coverage will be at the same benefit level as if the service or treatment had been rendered by a Participating Doctor or clinic.

Note: If we determine your condition did not meet the Prudent Layperson definition of an Urgent Care Situation, then Basic Plan level cost-sharing amounts will apply, subject to the limitations on Non-Participating Doctors or Hospitals set forth in Section 1, and whether services were rendered within or outside the state of North Dakota and its contiguous counties. See Section 1 in your COI for more information.

Note: For non-Emergency medical care or non-Urgent Care Situations when traveling outside our Service Area, benefits will be at the Basic level. See *Non-Participating Providers outside the Sanford Health Plan Service Area* in Section 1 of your COI.

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 give you the necessary health care services; or as approved and arranged by us.

Levels of Coverage

The benefit payment available under your Benefit Plan differs based on your choice of a Health Care Provider. We pay Doctors and Hospitals based on their relationship with us. Doctors or Hospitals that have signed contracts with us, and join our Network, will be paid at either the PPO Plan or Basic Plan level.

You should visit www.sanfordhealthplan.com/memberlogin for the Provider Directory, which lists both PPO and Basic level Participating (In-Network) Doctors and Hospitals. The Sanford Health Plan website is continuously updated and has the most up-to-date listing of Doctors and Hospitals. You may also call Member Services to request a Provider Directory.

In-Network Coverage

In-Network coverage is supplied under two (2) plan levels: 1) Basic Plan; or 2) PPO Plan. For more information, see *Selecting a Health Care Provider* in Section 1 of your COI.

Note: If you travel out of our Service Area (as defined in your COI) to seek medical treatment, without Preauthorization/Prior Approval, for a service that requires authorization/approval, your claims will be paid at the Basic Plan benefits. Find more in Section 1 of your COI.

How PPO vs. Basic Plan Determines Benefit Payment

PPO stands for "Preferred Provider Organization," which is a health plan that contracts with independent providers at a discount for services. Covered services must be from an NDPERS PPO Doctor or Hospital to get PPO Plan level benefits. Please see the NDPERS PPO Health Care Provider Listing by visiting www.sanfordhealthplan.com/memberlogin.

If a PPO Doctor or Hospital is: 1) not available in your area; or 2) if you either choose or are referred to a Doctor or Hospital not participating in the PPO, you will get the Basic Plan level benefits. For more information on how benefits are paid, see your COI.

Participating vs. Non-Participating Doctors and Hospitals

When you get health care services from a Participating Doctor or Hospital, they will send us needed information for you. You need to pay the Doctor or Hospital for any cost sharing amounts you owe (copays, deductible/coinsurance).

If you get health care services from a Non-Participating [has not signed a contract with Sanford Health Plan] Doctor or

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Hospital, you must tell us about the services you got and their cost. If we need copies of medical records to pay your claim, we will ask for your help in getting the records from the Non-Participating Doctor or Hospital.

When You Need Preauthorization/Prior Approval

There may be times when your Participating Doctor or Hospital will need to send, or refer, you to a hospital or other facility for inpatient care. In these cases, you or your Doctor must contact Utilization Management to get Preauthorization/Prior Approval before you get care. Referrals to Doctors or Hospitals who are Non-Participating [have not signed a contract with Sanford Health Plan], and to special Doctors or Hospitals, must get Preauthorization/Prior Approval by us to get In-Network coverage.

Note: All inpatient admissions, other than emergency or maternity, to a hospital or other facility, must get Preauthorization/Prior Approval.

Member Cost Sharing

A Cost Sharing Amount is the dollar amount you are responsible for paying when Covered Services are from a Doctor. **Note:** For more information on cost sharing amounts that apply to your specific Benefit Plan and Coverage Level, see Section 1 of your COI and your Summary of Benefits and Coverage (SBC).

Wellness Principles

It is better for all of us if you are seen in your Primary Care Doctor's office when you are healthy, so that he or she can work with you to keep you in good health instead of trying to treat you when you are already sick. That is why we encourage you to select a Primary Care Doctor to arrange your care and to offer you such services as yearly physical exams, maternity care, yearly gynecological exams, and immunizations. We have a commitment not only to treating you when you are ill, but also to helping you stay well. We will give you educational and wellness materials to teach you how to stay fit and live a healthy life: physically and mentally.

Preventive Health Services

For NDPERS Grandfathered Dakota Plan Members

We 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 any applicable Copayment, Deductible and Coinsurance amounts after the $200 Benefit Allowance has been met.

A doctor will guide you as to how often preventive services are need based on your age, gender and health status. 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 exam per Member per Benefit Period.
  - Routine diagnostic screenings.
  - Routine screening procedures for cancer.
- **Mammography Screening Services**
  - One (1) screening service for Members between the ages of 35 and 40.
  - One (1) screening service per year per Members ages 40 and older.
  - Additional benefits will be available for prostate cancer screening when Medically Necessary and ordered by a Doctor.
- **Routine Pap Smear**
  - One (1) Pap smear per Member per Benefit Period. Office Visit Copay applies.
  - Added benefits will be available for Pap smears when Medically Necessary and ordered by a Doctor.
- **Prostate Cancer Screening for the following: Asymptomatic Males Ages 50 and Older; Males ages 40 and Older of African American descent; and Males Ages 40 with a Family History of Prostate Cancer**
  - One (1) digital rectal exam yearly per Member. Office Visit Copay applies.
  - One (1) prostate-specific antigen test yearly per Member. Office Visit Copay applies.
  - Added benefits will be available for prostate cancer screening when Medically Necessary and ordered by a Doctor.
- **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.

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For NDPERS Dakota Non-Grandfathered Plan and HDHP Members

The Preventive Health Guidelines published by us are based on the latest U.S. Preventive Health Task Force and Bright Futures guidelines as well as CDC guidelines for immunizations. Our Preventive Health Guidelines help you and your doctor make sure you get the tests and immunizations you and your family need to stay healthy at each stage in your life.

If you would like a copy of our Preventive Health Guidelines or an immunization schedule, please contact Member Services toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 *(toll-free)* or visit www.sanfordhealthplan.com/memberlogin.

bWell Health Management Tool

We have an online health appraisal that is available to all our Members age 18 and older. Once filled out, the health appraisal gives a personalized report for you to review. This report gives actionable areas that you can choose to work on to improve your overall health and wellness status. The online health appraisal gives supportive self-management tools which are available 24/7 to our Members. To access the appraisal and tools, sign up for an account at www.sanfordhealthplan.com/memberlogin.

Case Management

Case management is a collaborative process that: assesses; plans; carries out; arranges; checks-in; and evaluates the choices and services required to meet your health needs. We use available communication and supports to encourage quality, effective outcomes.

Cases are detected for possible case management, based on requests for review, or a combination of things like:

a. admissions that go beyond the recommended or approved length of stay;
b. utilization of health care services that causes constant and/or extremely high costs; and
c. conditions that are known to need broad and/or long-term treatment or continuous care.

Our case management process allows professional case managers to assist you with certain complex and/or chronic health issues by coordinating complicated treatment plans and other types of complex patient care plans.

Working with case managers, we may authorize/approve coverage that extends beyond the limited time period and/or scope of treatment initially authorized/approved. This may include utilization management processes described below.

All decisions made through case management are based on the individual circumstances of your case. Each case is reviewed on its own merits by appropriate health plan medical professionals to ensure the best health outcome(s) for you. More information is available on your account at www.sanfordhealthplan.com/memberlogin or by calling our Care Management Department at (877) 652-1847.

Care Coordinator Program

Sanford Health Plan recognizes the key to you and your family's overall wellness is made up of more than just physical health. That's why we created our *Care Coordinator Program*. We believe that by helping connect you to community support and resources, we empower you to achieve and maintain your optimal wellness.

For example, your Care Coordinator will collaborate with other professionals who are invested in your wellbeing, such as case managers or your doctor. Your Care Coordinator may also connect you to programs and services that will help you manage family, financial and social needs, such as housing, support groups, or child care.

Healthy Pregnancy Program

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

To enroll, call our Care Management Department at (877) 652-1847 *(toll-free)* | TTY/TDD: (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 from your account at www.sanfordhealthplan.com/memberlogin, 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 you. When you enroll, a Case Manager will review a brief preterm labor risk assessment questionnaire with you. To complete this questionnaire, you will need your Member ID number; Doctor's name, address and telephone number; and expected due date.

As a program participant, you will get information about pregnancy and prenatal care.

Quality Improvement Program

We, and our Participating Doctors and Hospitals, have a duty to give you high quality care that is a good value, through ongoing monitoring, evaluation and improvement processes. The Quality Improvement (QI) program is how we monitor, evaluate, and improve the quality, safety and appropriateness of health care services, including behavioral health care. QI also addresses the quality of non-clinical aspects of service, including availability; accessibility; continuity and coordination of care; case management; discharge planning; Preauthorization/Prior Approval; Provider reimbursements; and Complaints and Appeals.

A summary of QI and our annual HEDIS® reports (annual HEDIS® performance statistics and updates on quality improvement activities) are available at www.sanfordhealthplan.com/ndpers or by calling our Care Management Department at (877) 652-1847.

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Our Quality Committees

The Board of Directors maintains the ultimate authority over our Quality Improvement Program. To implement our Quality Improvement Program, the Board has delegated its responsibility for monitoring the organization's Quality Improvement Process to the Chief Medical Officer, through a formal Board resolution. The Chief Medical Officer, along with the help of the Quality Improvement Committees, ensures that the Board meets its responsibility to monitor, evaluate and revise the clinical and service quality issues and care delivery system. The Health Plan Quality Improvement Committee is made up of Plan managers and staff and is charged with supporting our Board of Directors and Chief Medical Officer in meeting quality assurance goals on issues of service.

The Physician Quality Committee consists of Physician members. This Committee is charged with supporting our Board of Directors and Chief Medical Officer in meeting quality assurance goals on issues of care. They also have the responsibility of developing and continually evaluating the review criteria used in the evaluation of appropriate utilization. The Committee is also responsible for developing, overseeing, reviewing and updating our therapeutic drug Formulary based on clinical, quality and cost considerations.

Health Management Programs

Our Health Management Programs are developed to identify populations proactively with, or at risk for, chronic medical conditions. These programs support the doctor-patient relationship and plan of care and continuously evaluate clinical and economic outcomes with the goal of improving your overall health condition.

Right now, Sanford Health Plan has health management programs for:

- Diabetes
- High Blood Pressure
- Heart Disease
- Heart Failure
- Asthma
- Attention Deficit/Hyperactivity Disorder (ADHD)

Eligible Members get an initial program packet which has information on how to use the program's services, the types of interventions that are involved and how to contact us regarding any questions related to the program or its services. To opt out of a program, you need only to contact us and you will be taken off the mailing list.

If you are interested in receiving information or in joining one of these health management programs and you have not yet been identified as eligible for the program, you may contact our Care Management Department toll free at (877) 652-1847 to get this information. Additional information is also available on these programs at www.sanfordhealthplan.com/memberlogin or email quality@sanfordhealth.org.

mySanfordNurse

mySanfordNurse is a 24-hour health information resource that provides answers to health-related questions that arise outside of your healthcare visits. You may call (888) 315-0886 to visit with a nurse, or register/visit www.sanfordhealthplan.com/memberlogin and submit a question online.

Claim Payment Procedures

When to File a Claim

The only time you will need to file a claim is if a Non-Participating Provider did not file one for you. 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.

Upon processing of the claim, you will get a statement explaining your benefits (Explanation of Benefits – EOB) within *thirty (30)* days of receipt of the claim. Remember, we will settle directly with the Practitioner and/or Provider for services you got. You will then be responsible for paying any applicable amounts (this includes, but is not limited to, copay/coinsurance and deductible amounts).

How to File a Claim

A separate claim form must be completed for each member of your family who got health care services, and for each Provider who cared for you. To obtain a form, visit www.sanfordhealthplan.com/memberlogin or call Sanford Health Plan Member Services and request a form be mailed to you.

You must complete all sections of the claim form and attach a copy of your Practitioner or Provider's itemized statement. This statement from Practitioners and/or Providers should show:

1. Covered Member's name and ID number;
2. Name and address of the Practitioner and/or Provider or Facility that delivered the service or supply;
3. Dates Member got 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

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8. Receipts/Member Costs, if you paid for your services.

Please make sure you sign the form and include a daytime phone number where you can be reached to answer any questions.

Mail all information, including your claim form and itemized statement(s) to:

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

How a Medical Claim Gets Paid

1. You go to the doctor or facility to get medical services and present your Sanford Health Plan identification card.
2. After your services are completed, your provider's office prepares a claim to send to Sanford Health Plan for processing. You may also get a bill from the provider at this time. Participating providers may take up to 180 days to file a claim with Sanford Health Plan. You may contact the provider's office to determine how quickly your claim will be submitted to Sanford Health Plan. It may be helpful to wait to pay the provider bill until we have processed your claim.
3. Once Sanford Health Plan gets a claim from your provider, the claim is processed for payment, typically within 30 days or less. Claim payments are generally made directly to the provider. Once your claim is processed, an Explanation of Benefits (EOB) is generated and mailed to your home address.

Pharmacy Claims

You must fill prescriptions at Participating pharmacies for Cost Sharing amounts to apply. A Participating Pharmacy has signed a contract with Sanford Health Plan; and agrees not to charge or collect any amount from you that exceeds your Cost Sharing Amounts. Participating Pharmacies must submit claims on your behalf. A listing of our Participating pharmacies is available upon request or can be viewed on your account at www.sanfordhealthplan.com/memberlogin.

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.

If you choose to go to a Non-Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy. If you get Prescription Medications from a Non-participating Pharmacy, you are responsible for submitting appropriate reimbursement information to Sanford Health Plan. Payment for covered Prescription Medications will be sent to you. Any charges in excess of the Allowed Charge are your responsibility.

If submitting pharmacy claims, you may attach receipts for more than one pharmacy to the claim form as long as all prescriptions are for the same person. To obtain a form, visit www.sanfordhealthplan.com/memberlogin or call Member Services and request a form be mailed to you.

Coordination of Benefits

In some cases, you may be covered by another insurance plan, in addition to your coverage with us. If so, we will work with the other insurer to be sure you get full benefits without paying for services twice. If you are covered by another insurance plan, please tell Member Services so that we can find out whether another insurer may be responsible for paying for some of your care.

If your eligibility shifts to Medicaid or Medicare, please notify us as soon as possible so that we may coordinate your benefits appropriately.

Member Bill Audit Program

Upon receiving notice of a claims payment, or Explanation of Benefits (EOB), from us, you are encouraged to audit your medical bills and notify us of any services which are improperly billed or of services that you did not get.

If, upon audit of a bill, an error of $40 or more is found, you will get 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*, you must complete a *Member Bill Audit Refund Request Form*. To obtain a form, visit www.sanfordhealthplan.com/memberlogin or call Member Services 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*, in your COI.

Member Satisfaction Principles

We are committed to your satisfaction. One of the ways that we ensure that our services meet the needs of our Members is to ask you how we, and the Practitioners and Providers in our network, have been performing. We value what you say and we want to continue to improve our services. Therefore, as a Member of our Plan, you may get a survey from us at least once a year so that you can tell us how satisfied you are with the services you get. You may also be asked to fill out a survey after an appointment with a Doctor or you may periodically get a telephone call from one of our Member Services Representatives. Your satisfaction is important to us.

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We encourage you to contact us with your comments and concerns. Member Services may be reached toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 *(toll-free)* or by writing:

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

You will also have an opportunity to express your opinions on matters of Plan policy and operations through Member representation on the Board of Directors.

Understanding Your EOB

The following picture describes important terms used in your Explanation of Benefits (EOB) and throughout the claims payment process. Please take the time to become familiar with these terms to understand your benefit plan better.

An EOB shows you, or your covered family member, the benefits coverage you got for the services billed to us by Doctor. The Explanation of Benefits lets you know the dollar amount of services that were billed by your Doctor and how that amount is applied to deductible, coinsurance or copayments, or if any of the charges were for non-covered services. If you would like to sign up for electronic EOBs, visit www.sanfordhealthplan.com/memberlogin.

Understanding Your EOB
(EOB=Explanation of Benefits)

This area will contain important messages – take the time to read!

Member benefits information at your fingertips, anytime, anywhere!

Create an account at www.sanfordhealthplan.com/memberlogin to:

- View your claims and deductible status
- Find a participating provider or pharmacy
- View your ID card
- Securely send a message to Sanford Health Plan

Explanation of Benefits – This is NOT a Bill

Member#: 11122233301 **Member Name:** Jane Doe **Provider:** 1234567892, Provider John
Claim#: 123456 **Vendor:** Sanford Clinic

Service Date	*Description	Amount Billed	Discount Amount	Non-Covered Amount	Reason Codes	Allowed Amount	Copay	Deductible	Co-insurance	Amount Paid
09/24/2013	73	117.00	70.49	0.00		46.51	0.00	46.51	0.00	0.00
09/24/2013	73	117.00	70.49	0.00		46.51	0.00	46.51	0.00	0.00
09/24/2013	98	226.00	70.31	0.00		155.69	20.00	0.00	0.00	135.69
Totals		460.00	211.29	0.00		248.71	20.00	93.02	0.00	135.69

Actual date you got the service

A code indicating the description of the services you got.

The amount billed to us by your provider.

The amount discounted by the Provider as a part of contracting with Sanford Health Plan.

Amount not eligible for payment by Sanford Health Plan.

A description of why a claim was paid or denied.

The pre-negotiated rate paid to Participating PPO and Basic providers for covered services. For Non-Participating providers, it is the reasonable cost.

Copay amounts owed to the provider.

The deductible is the amount you pay *before* your health insurance plan begins to pay for covered services.

The coinsurance is the percentage of charges to be paid by you for covered services, after the deductible is met. It is based on the "allowed amount" and reflects your benefits (i.e. 80/20 for the PPO plan).

Amount Sanford Health Plan has paid to the provider for the claim(s).

The total your responsibility for this claim is: $113.02

***Description/Messages**

73 DIAGNOSIS MEDICAL
98 PROFESSIONAL (PHYSICIAN) VISIT - OFFICE
*** For additional information about benefits, please see to your COI. For questions about the determination of your benefits, please contact Member Services at (800) 499-3416. If your claim was denied in whole or in part, you have the right to appeal by writing to Sanford Health Plan. Please submit your written appeal to: Sanford Health Plan, ATTN: NDPERS, PO Box 91110, Sioux Falls, SD 57109-1110. Appeals must be submitted within 180 days.

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Utilization Management Department Functions

Utilization Management performs three primary functions: Utilization Review (which includes Prospective or Pre-service Review, Concurrent Review, Retrospective or Post-service Reviews and Focused Reviews), Case Management and Discharge Planning. Additional information on these Utilization Management functions can be found in your COI.

Utilization Management is available to Doctors, Providers and Members to discuss utilization review issues between the hours of 8 a.m. to 5:30 p.m. Central Time, Monday through Friday (excluding holidays). Utilization Management's toll-free number is (888) 315-0885 (a toll-free TTY/TDD line is also available at (877) 652-1844). After business hours, you may leave a confidential voicemail for Utilization Management and someone will return your call on the following business day. You can also fax us at (701) 234-4547. For information on how to obtain language assistance to discuss Utilization Management issues, please see the *Special Communication Services* section of this handbook.

Your COI has information on Preauthorization/Prior Approval; you may also find information on your account at www.sanfordhealthplan.com/memberlogin.

Provider Financial Incentives Policy

Sanford Health Plan does not specifically reward Practitioners and/or Providers or other individuals conducting Utilization Management and/or Utilization Review for issuing denials of coverage or benefits. Financial incentives for Utilization Management and/or Utilization Review decision makers do not encourage decisions that result in underutilization.

New Technology

To ensure you have access to safe and effective care, we have adopted a formal mechanism to evaluate and address new developments in medical and behavioral procedures, pharmaceuticals and devices. The Physician Quality Committee is responsible for recognizing and evaluating new health care services, procedures and pharmacological treatments as well as their application for Plan Members. A specialist representing the new technology (i.e. physician, pharmacist, etc.), if not a your of the Committee, will be invited to present the technological aspects of the service, procedure, or pharmacological treatment. Published scientific evidence and information from literature and the Internet will be reviewed to make the appropriate decisions. The technology must have final approval from appropriate government regulatory bodies.

Once the new technology or new application of an existing technology has been reviewed by the Physician Quality Committee, this review can result in either of two types of decisions:

1. A policy determination to include a new technology as a covered benefit in the future.
2. A case-based decision on whether or not to cover a specifically requested service. There must be evidence that case-based decisions result in a review of medical necessity guidelines and procedures for possible revision.

Upon approval from the Board of Directors, we will notify you and Doctors by way of the newsletter, if appropriate.

Member Complaint and Appeal Procedures & Independent External Reviews

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. You, your doctor, your Authorized Representative, or an attorney, have the right to file a complaint or an appeal of any Adverse Determination by Sanford Health Plan. You or your legal guardian may tell us that you want someone to speak for you. You should tell us in writing if you want someone to speak for you when you appeal. For Expedited Appeals, a Doctor with knowledge of your condition may act as your Authorized Representative.

You may contact the North Dakota Insurance Commissioner anytime 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)*

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 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 preexisting condition exclusion, 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 COI, and deny claims.

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

Complaint: An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and Doctor Complaints.

External Review: An External Review is a request for an independent, External Review of a medical necessity final determination made by Sanford Health Plan through its External Appeals process. Information on how to initiate an External Review request is included in the Notice of Adverse Determination as well as your COI.

Note: *For Members in the NDPERS Grandfathered Dakota Plan, you only have the right to an independent, third party, binding review after you have exhausted our internal Appeal process and our decision is unfavorable to you.*

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For more information how to submit a complaint or appeal, our procedure for timely handling of complaints and appeals, and your rights to an independent External Review, please see your COI for information. You may also find this information by visiting www.sanfordhealthplan.com/memberlogin or by calling to request this information from Member Services at (800) 499-3416 *(toll-free)*.

Expedited Appeals and External Reviews

An **Expedited Appeal Procedure** is used when a condition presents as part of an **Urgent Care Situation**, as defined previously in this Handbook and in your COI.

For Non-Grandfathered Benefit Plan Members only, when submitting an Expedited Appeal, a request for an Expedited External Review may be submitted concurrently. This can be done orally or in writing, and we will accept all necessary information by telephone or electronically. In such situations, the Doctor who made the initial Adverse Determination may review the appeal and overturn the previous decision.

A complete description of your Appeal and/or External Review Rights and processes for each will be included in applicable written correspondence you get from us.

Termination of Membership

If you are not able to continue coverage under an NDPERS benefit plan, please see your Certificate of Coverage for options after coverage has ended.

There may be other coverage options for you 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 your individual circumstances. To learn more, visit www.healthcare.gov or call the Marketplace Call Center toll-free at (800) 318-2596 | TTY/TDD: (855) 889-4325.

NDPERS GF/NGF/HDHP HP-0497 7/15

DRAFT

Special Notices

for NDPERS Grandfathered Dakota Plan members

North Dakota Public Employees Retirement System
Dakota Plan Health Benefits

SANFORD HEALTH PLAN

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.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance, including group health plan coverage, Medicaid or State Children's Health Insurance Program (SCHIP), you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents other coverage). However, the following conditions apply:

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/ndpers 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 (800) 318-2596 | TTY/TDD: (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 (see "Service Area" in the *Introduction* Section of your Certificate of Insurance), 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/ndpers 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 (800) 318-2596 | TTY/TDD: (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.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **(877) KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **(866) 444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2015. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: www.myalhipp.com Phone: (855) 692-5447	Website: dch.georgia.gov - *Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP)* Phone: (800) 869-1150
ALASKA – Medicaid	**INDIANA – Medicaid**
Website: health.hss.state.ak.us/dpa/programs/medicaid Phone (Outside of Anchorage): (888) 318-8890 Phone (Anchorage): (907) 269-6529	Website: www.in.gov/fssa Phone: (800) 889-9949
COLORADO – Medicaid	**IOWA – Medicaid**
Medicaid Website: www.colorado.gov/hcpf Medicaid Customer Contact Center: (800) 221-3943	Website: www.dhs.state.ia.us/hipp Phone: (888) 346-9562
FLORIDA – Medicaid	**KANSAS – Medicaid**
Website: www.flmedicaidtplrecovery.com Phone: (877) 357-3268	Website: www.kdheks.gov/hcf Phone: (800) 792-4884
KENTUCKY – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: chfs.ky.gov/dms/default.htm Phone: (800) 635-2570	Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: (603) 271-5218
LOUISIANA – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: www.lahipp.dhh.louisiana.gov Phone: (888) 695-2447	Medicaid Website: www.state.nj.us/humanservices/dmahs/clients/medicaid Medicaid Phone: (609) 631-2392 CHIP Website: www.njfamilycare.org/index.html CHIP Phone: (800) (701) 0710
MAINE – Medicaid	**NEW YORK – Medicaid**
Website: www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: (800) 977-6740 | TTY: (800) 977-6741	Website: www.nyhealth.gov/health_care/medicaid Phone: (800) 541-2831
MASSACHUSETTS – Medicaid and CHIP	**NORTH CAROLINA – Medicaid**
Website: www.mass.gov/MassHealth Phone: (800) 462-1120	Website: www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	**NORTH DAKOTA – Medicaid**
Website: www.dhs.state.mn.us/id_006254 - *Click on Health Care, then Medical Assistance* Phone: (800) 657-3739	Website: www.nd.gov/dhs/services/medicalserv/medicaid Phone: (800) 755-2604
MISSOURI – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: (573) 751-2005	Website: www.insureoklahoma.org Phone: (888) 365-3742
MONTANA – Medicaid	**OREGON – Medicaid**
Website: medicaid.mt.gov/member Phone: (800) 694-3084	Website: www.oregonhealthykids.gov www.hijossaludablesoregon.gov Phone: (800) 699-9075

NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
Website: www.ACCESSNebraska.ne.gov Phone: (855) 632-7633	Website: www.dpw.state.pa.us/hipp Phone: (800) 692-7462
NEVADA – Medicaid	**RHODE ISLAND – Medicaid**
Medicaid Website: dwss.nv.gov Medicaid Phone: (800) 992-0900	Website: www.ohhs.ri.gov Phone: (401) 462-5300
SOUTH CAROLINA – Medicaid	**VIRGINIA – Medicaid and CHIP**
Website: www.scdhhs.gov Phone: (888) 549-0820	Medicaid Website: www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: (800) 432-5924 CHIP Website: www.coverva.org/programs_premium_assistance.cfm CHIP Phone: (855) 242-8282
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: dss.sd.gov Phone: (888) 828-0059	Website: www.hca.wa.gov/medicaid/premiumpymt/pages/ index.aspx Phone: (800) 562-3022 ext. 15473
TEXAS – Medicaid	**WEST VIRGINIA – Medicaid**
Website: www.gethipptexas.com Phone: (800) 440-0493	Website: www.dhhr.wv.gov/bms Phone: (877) 598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: health.utah.gov/medicaid CHIP Website: health.utah.gov/chip Phone: (866) 435-7414	Website: www.dhs.wisconsin.gov/badgercareplus/p-10095.htm Phone: (800) 362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: www.greenmountaincare.org Phone: (800) 250-8427	Website: health.wyo.gov/healthcarefin/equalitycare Phone: (307) 777-7531

For more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
(866) 444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
(877) 267-2323, Menu Option 4, Ext. 61565

OMB Control Number 1210-0137 (expires 10/31/2016)

Privacy

Confidentiality and Disclosure of Personal Health Information

Sanford Health Plan receives and maintains a great deal of personal health information about our Members and we protect the privacy of all patient information in accordance with state privacy and federal HIPAA regulations.

We will share personal health information of Members as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our Members' personal health information and to provide Members with notice of our legal duties and privacy practices with respect to your personal health information.

No use or disclosure of personal health information may be made by any applicable person to a plan sponsor (i.e. employer) unless at least one of the following conditions is met:

1. Sanford Health Plan receives a signed certification from the employer that the plan documents restrict the use and disclosure of personal health information as required by the HIPAA regulations on privacy and confidentiality, and that the employer agrees to comply with the restrictions, and the information has been requested by the employer for use in carrying out plan administrative functions only (i.e. employers must certify they do not use or disclose the information for employment-related actions and decisions);
2. The information provided to the employer is summary health information, and the employer has requested it for the purpose of obtaining premium quotes, or determining whether to amend, modify or terminate the sponsored health plan (summary health information means personal health information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom an employer has provided health benefits under a group health plan, and from which all individual identifiers are eliminated);
3. The information provided to the employer is enrollment or disenrollment information or information on whether individuals are participating in the sponsored plan, and the employer has requested it for the purpose of administering the sponsored plan; or
4. There is a signed authorization by the Member or the Member's representative, which specifically authorizes the use or disclosure. A signed authorization form is required for uses by or disclosures to an employer if the use or disclosure does not meet the conditions described in paragraph 1, 2 or 3 above. Prior to any use by or disclosure to an employer under this paragraph 4, the procedures for obtaining and verifying authorization described in the policy for Obtaining and Complying With Member Authorizations must be followed.

Protection of Oral, Written and Electronic Information across the Organization

All Members of the Sanford Health Plan workforce are required to comply with the provisions of the Plan's workforce policy on *General Obligations Regarding Uses and Disclosures of Personal Health Information*. We consider workforce to include employees (Part time, Full time, and PRN), volunteers, trainees, and other persons whose work performance is under the direct control of Sanford Health Plan, whether or not they are paid by Sanford Health Plan.

- Personal health information of a Member may not be used within Sanford Health Plan for non-health plan functions, unless such use or disclosure is specifically authorized by a signed authorization by the Member.
- When using, requesting or disclosing a Member's personal health information, all reasonable efforts are made to limit the information used, requested or disclosed to that which is minimally necessary to accomplish the purpose of the use or disclosure in accordance with our Minimum Necessary Policy.
- All workforce members must attend required educational and training sessions relating to privacy and confidentiality of personal health information.
- All workforce members must take reasonable steps to safeguard personal health information from any intentional or unintentional use or disclosure that is in violation of this or any other policy of Sanford Health Plan. Such safeguarding includes, but is not limited to, storing personal health information in a cabinet or closed file at the end of the workday; maintaining privacy during oral discussions of personal health information; restricting electronic transmission of personal health information to job related duties; and disposing of documents strictly in accordance with policies of Sanford Health Plan.
- Sanford Health Plan will take appropriate disciplinary measures against workforce members who violate any policy or procedure of Sanford Health Plan concerning the privacy of member information. Discipline for such infractions of our privacy policies and procedures may include reprimand, suspension, or discharge of the responsible workforce member, depending on the severity of the misconduct.

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 our Member Services Department at (800) 499-3416 (toll-free) | TTY/TDD (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 physician 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.
- **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
(800) 499-3416 (toll-free) | TTY/TDD (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 is available upon request and on our website at www.sanfordhealthplan.com/ndpers.

Effective Date

This Notice of Privacy Practices was 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.

Advance Directives

We are required to tell our members about advance directive laws. An advance directive is a written instruction, such as a living will or health care power of attorney. It is law regarding the instructions you can write to tell your doctors and family what kind of care you want if you are too sick to make health care decisions on your own (i.e. a person who has suffered a head injury, is in a coma, a patient with advanced Alzheimer's disease, or a person in the last stages of cancer). The instructions are written and witnessed in advance of the possible need for the directives. Advance directives can provide peace of mind now and will protect your right to health care the way you want it.

Utilization Management

The Plan's Utilization Management Department performs three primary functions: Utilization Review (Prospective or Pre-service Review, Concurrent Review, Retrospective or Post-service Reviews), Case Management and Discharge Planning.

For information on how to obtain language assistance to discuss Utilization Management issues, please see the Special Communication Services section at the end of this notice.

The Utilization Management Department is available between the business hours of 8 a.m. to 5 p.m. Central Time, Monday through Friday (excluding holidays. Practitioners, Providers and Members may call the Plan's toll-free number (888) 315-0885 | TTY/TDD: (877) 652-1844 (toll-free). After business hours, you may leave a confidential voicemail and someone will return your call on the next business day. The Utilization Management fax number is (701) 234-4547.

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, regardless of the hour. For *Minnesota Members*, any communication received after midnight Monday through Friday will be responded to on the same business day. 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.

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 of your Certificate of Insurance)*. 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.

Medical Necessity

The Plan determines whether a service, treatment, technology, or prescription drug or supply (service) is Medically Necessary by applying the following criteria:

a. Must be consistent with generally accepted standards of medical practice as recognized by the Plan, as determined by health care practitioners in the same or similar specialty as typically manages the condition, procedure, or treatment or issue.
b. Help restore or maintain the member's health.
c. Be required for reasons other than the convenience of the covered person of his/her physician, or solely for custodial, comfort, convenience, appearance, educational, recreational or vocational reasons.
d. Prevent deterioration of the member's condition.
e. Prevent the reasonably likely onset of a health problem or detect an incipient problem.
f. Not considered experimental or investigational.

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the criterion for medical necessity determinations is available upon request to any current or potential participant, beneficiary, or contracting provider.

Not all services prescribed or recommended by Plan physicians are necessarily covered by the Plan. The Plan's Chief Medical Officer or designee, using consultants as needed, makes the final determination of which services are covered by the Plan, in conjunction with the Certificate of Insurance. For more information, visit www.sanfordhealthplan.com/memberlogin or contact Member Services.

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

"Prospective Review" is the review conducted prior to the provision of a health service. Prospective (Pre-service) review decisions are designed to facilitate early identification of the treatment plan to ensure medical management and available resources are provided throughout an episode of care.

Preauthorization/Prior Approval is a determination by the Plan that a request for a benefit has been reviewed and, based on the information provided, satisfies the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

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 of your COI. 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.

For medical necessity requests, the Utilization Management Department will review Member profile information against standard criteria. For benefit determinations, a person assigned to coordinate the benefit, Denial and Appeal process will review the request against Plan Policy. Determinations and notifications of decisions to the Member and Practitioner and/or Provider are made within the timeframes required by state and federal laws, and NCQA standards.

Urgent Care Request determinations are made as soon as possible but no later than the timeframe required by state law and NCQA standards. Certain circumstances may allow for an extension, for example, due to lack of necessary information to make the determination. Please refer to your Certificate of Insurance. For more information, visit www.sanfordhealthplan.com/memberlogin or contact Member Services.

Services that Require Prospective (Pre-service) Review and 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) of your Certificate of Insurance:
   a. Prosthetic Limbs requiring replacement within 5 years;
   b. Insulin infusion devices;
   c. Insulin pumps;
   d. Continuous Glucose Monitoring Systems (CGM);
   e. Electric wheelchairs;
   f. External hearing aids for the treatment of a hearing loss that is not due to the gradual deterioration that occurs with aging and/or other lifestyle factors. For details, see Section 5(a) of your COI, "*Hearing services (testing, treatment, and supplies)*";
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 your Certificate of Insurance.

Please refer to your Certificate of Insurance for more information on Preauthorization/Prior Approval requirements.

Urgent Care Requests

In determining whether a request is "Urgent," the Plan shall apply the judgment of a Prudent Layperson, as defined in the Certificate of Insurance. When a Practitioner with knowledge of the Member's medical condition determines a Member's condition to be an Urgent Care Situation, the Plan shall treat the Prospective Review as an Urgent Care Request. For more information, visit www.sanfordhealthplan.com/memberlogin or contact Member Services.

Prospective (Pre-service) Review is not required for Emergency Conditions. However, if you are admitted, the Plan must be notified as soon as reasonably possible; but no later than *forty-eight (48)* hours after you are physically or mentally able to do so.

Concurrent Review

"Concurrent Review" is utilization review conducted during a Member's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting. It is utilized when a request for an extension of an approved ongoing course of treatment over a period of time or number of treatments is warranted. Additional stay days must meet the continued stay review criteria and, if acute level of care criteria are not met, a decision to certify further treatment must be made at that time.

The Utilization Management Department will review Member profile information against standard criteria. Determinations and notifications of decisions to the Member and Practitioner and/or Provider are made by the Utilization Management Department within the timeframes required by State law and NCQA standards. Urgent care request determinations are made as soon as possible but no later than the timeframe required by state law and NCQA standards. Please refer to your Certificate of Insurance for Sanford Health Plan's procedure for timely handling of concurrent review. For more information, visit www.sanfordhealthplan.com/memberlogin or contact Member Services.

Retrospective Review (Post-service)

Retrospective Review means any review of a request for a benefit that is not a Prospective (Pre-service) Review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication for payment. Retrospective (Post-service) Review will be utilized by Sanford Health Plan to review services that have already been utilized by the Member.

The Utilization Management Department will review Member profile information against standard criteria. Determinations and notifications of decisions to the Member and Practitioner and/or Provider are made by the Utilization Management Department within the timeframes required

by State law and NCQA standards. Certain circumstances may allow for an extension, for example, due to lack of necessary information to make the determination. Please refer to your Certificate of Insurance for Sanford Health Plan's procedure for timely handling of Retrospective (Post-service) Review requests and for details on extensions for special circumstances. For more information, visit www.sanfordhealthplan.com/memberlogin or contact Member Services.

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 in your Certificate of Insurance.

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.

If you would like more information about this program, and whether you meet the criteria to participate in the program, please contact our Care Management Team toll-free at (877) 652-1847 | TTY/TDD: (877) 652-1844 (toll-free) or quality@sanfordhealth.org.

Discharge Planning

The Utilization Management Coordinator begins assessing discharge planning needs at the beginning of any hospital admission. The reviewer assists in the identification of Members with post hospital care needs for which social service and hospital discharge planning services would be appropriate. The Utilization Management Coordinator can, with the advice and counsel of the attending Practitioner, work actively with social services and hospital discharge planning to assist in coordinating inter-hospital transfer, transfers to nursing homes, home health care, transportation, and any durable medical equipment needed.

Member Complaint and Appeal Procedures & Independent External Review Rights

Sanford Health Plan has procedures in place for responding to member complaints and appeals of adverse determinations. Decisions are made in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Members, health care Practitioners and/or Providers with knowledge of the Member's medical condition, authorized representative of the Member and/or an attorney may request a review of any Adverse 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 is needed by the Plan to communicate with an Authorized Representative.

Please refer to your Certificate of Insurance for information on how to submit a complaint or appeal, the Plan's procedure for timely handling of complaints and appeals, and any right you may have to request an independent External Review. For more information, visit www.sanfordhealthplan.com/memberlogin or contact Member Services toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (toll-free).

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 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: Means a request to change a previous Adverse Determination made by Sanford Health Plan.

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 Determinations and/or Appeals by date, service, procedure, substance of the complaint/appeal (including any clinical aspects/details), and reason for the complaint/adverse determination/appeal. The Appeal file includes telephone notification, and documentation including the date; the name of the person spoken to; the Member; the service, procedure, or admission certified; and the date of the service, procedure, or Adverse Determination and reason for determination, as well as any actions taken.

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 response provided 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.

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 an adverse determination made by Sanford Health Plan through its External Review process.

Utilization Review: Means the evaluation of the necessity, appropriateness, and facilities used by a Member for the purpose of determining medical necessity of the service or admission.

Urgent Care Situation: A degree of illness or injury which is less severe than an Emergency Condition, but requires prompt medical attention within 72-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 could:

1. 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, 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.

A Prudent Layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek Emergency medical treatment

Complaint Procedure

A Member may register a complaint by calling Member Services toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (toll-free). If the Member's complaint cannot be resolved through a telephone call, the Plan will provide them with a Complaint form to complete and return to Member Services; upon request, Member Services will provide assistance in submitting a complaint.

Complaint and Appeal decisions and notifications of decisions to the Member and Practitioner and/or Provider are made by the Plan within the timeframes required by State law and NCQA standards. Please refer to the Certificate of Insurance, the Notice of Adverse Determination, or visit www.sanfordhealthplan.com/memberlogin for the Plan's procedures on timely handling of Complaints and Appeals, how to initiate the Complaint and Appeal process, and the Member's rights to an independent External Review. You may also contact Member Services.

Right to Civil Action

If you remain dissatisfied with Sanford Health Plan's determination after completing the required appeals process, you may have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

Appeal Procedures

In North Dakota, appeals must be submitted within *one hundred eighty* (180) days after the date of receipt of a notice of Adverse Determination.

Types of Appeals

- A **Pre-service appeal** is a request to change an Adverse Determination that Sanford Health Plan approved in whole or in part in advance of the Member obtaining care or services.
- A **Post-service appeal** is a request to change an Adverse Determination for care or services already received by the Member. This includes appeals related to coverage and medical necessity decisions as well as appeals related to the outcome of a complaint.
- 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 be conducted within 72-hours (24-hours for South Dakota members).
- An **External Review** is a request for an independent, External Review of a medical necessity final determination made by Sanford Health Plan through its External Appeals process.

Pre-service (Prior Authorization) Appeal Process

If Sanford Health Plan has declined to provide benefits, in whole or in part, for the requested treatment or service, or if the Member believes the determination was made in error, the Member has the right to appeal. An appeal may be requested by a Member, his or her authorized representative, practitioner or Provider by writing or calling Member Services toll-free at (800) 499-3416 | TTY/TDD: (877) 652-1844 (toll-free), if the determination for a request for service was adverse to the Member. The Member's Appeals Rights are included in the Member's initial Notice of Adverse Determination. Sanford Health 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 Appeal.

Post-service Appeal Process

If any Member or authorized representative as designated in writing by the Member acting on behalf of the Member, has a question, complaint or other problem regarding claims payment for a Post-service(s) or those services already received, any aspect of the Plan's services, his or her relationship with the Plan and its Practitioners and/or Providers other than a complaint regarding Preauthorization/Prior Approval, or authorization decision, the Member or the authorized representative should contact the Plan by calling or sending a written complaint to the following address:

Sanford Health Plan
ATTN: NDPERS Appeals
PO Box 91110
Sioux Falls, SD 57109-1110
Phone: (800) 499-3416 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free)

The Member or Authorized Representative may also submit an appeal by logging into their account at www.sanfordhealthplan.com/ndpers using the *Ask a question* feature. Sanford Health 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 Appeal.

Expedited Appeal for Urgent Care Process

If the Member's situation meets the definition of Urgent under the law, the Member's review will generally be conducted within 72-hours. Generally, an Urgent Care Situation is one in which the Member's health may be in serious jeopardy, or in the opinion of their physician, the Member may experience pain that cannot be adequately controlled while waiting for a decision on an appeal. If the situation is Urgent, an Expedited Appeal may be requested by contacting us toll-free at (888) 315-0885 | TTY/TDD: (877) 652-1844 (toll-free).

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.

Continued Coverage for Concurrent Care during an Appeal

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 24 hours.

External Review Process

The Plan will follow the procedure for providing independent, external review of final determinations as outlined by the Affordable Care Act. Accordingly, an Independent External Review is not available for Benefit Adverse Determinations. Information on how to initiate an External Review request is included in the Notice of Adverse Determination as well as your Certificate of Insurance. For more information, visit www.sanfordhealthplan.com/memberlogin or contact Member Services.

Special Communication Services

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)*.

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.

All Special Communication Services are available for the entirety of Plan services, including the Complaint/Appeal process, Preauthorization/Prior Approval, and any other Member benefit.