

This Amendment is effective July 1, 2016, and applies to coverage under the following North Dakota Public Employees Retirement System (NDPERS) Certificates of Insurance:

- **Grandfathered Dakota PPO/Basic Plan**
- **Non-Grandfathered Dakota PPO/Basic Plan**
- **Non-Grandfathered Dakota High Deductible Health Plan**

Please review this document carefully, and keep it with your Policy for future reference.

Help understanding this document is free.

If you would like this policy in another format (for example, a larger font size or a file for use with assistive technology, like a screen reader), please call us at (800) 499-3416 (toll-free) |
TTY/TDD: (877) 652-1844 (toll-free).

Help in a language other than English is also free.

Please call (800) 892-0675 (toll-free) to connect with us using free translation services.

Statement of Eligibility to Receive Benefits

In the Preface and Section 3 Enrollment, the following has been amended as follows added:

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

Value-Added Program

In the Preface, the following subsection is added:

Value-Added Program

Sanford Health Plan may, from time to time, offer health or fitness related programs to our Members through which Members may access discounted rates from certain vendors for products and services available to the general public. Products and services available under any such program are not Covered Services. Any such programs are not guaranteed and could be discontinued at any time. Sanford Health Plan does not endorse any vendor, product or service associated with such a program and the vendors are solely responsible for the products and services you receive.

Fiduciary Duties

In the Preface, the following subsection is added:

Claims Administrator is a Fiduciary

Except for direct member appeals regarding an infertility services deductible, the North Dakota Public Employees Retirement Board has delegated to the Claims Administrator, herein known as Sanford Health Plan, benefit claims and appeals. Sanford Health Plan is a Plan fiduciary for these benefit claims and appeals only. As such, the Claims Administrator has the final and discretionary authority to determine these claims and appeals, and has the final and discretionary authority to interpret all terms of the Plan and make factual determinations necessary to make the claim and appeal determinations. The decision made by the Claims Administrator on review is final and binding, subject to your right to file a lawsuit under other applicable laws. This decision making authority is limited only by the duties imposed. Any determination by the Claims Administrator is intended to be given deference by courts to the maximum extent allowed under applicable laws.

Notice of Non-Discrimination

In the Preface, the following subsection is added:

Notice of Non-Discrimination

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, gender, gender identity, sex or sexual orientation. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, gender, gender identity, sex or sexual orientation.

Sanford Health Plan:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, contact Sanford Health Plan Member Services by calling (701) 417-6500 or (800) 499-3416 (*toll-free*) or TTY/TDD: (877) 652-1844 (*toll-free*) or writing PO Box 91110, Sioux Falls, SD 57109-1110.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Sanford Health Plan Member Services by calling (701) 417-6500 or (800) 499-3416 (*toll-free*) or TTY/TDD: (877) 652-1844 (*toll-free*) or writing PO Box 91110, Sioux Falls, SD 57109-1110.

You can file a grievance in person or by mail or phone. If you need help filing a grievance contact Sanford Health Plan Member Services by calling (701) 417-6500 or (800) 499-3416 (*toll-free*) or TTY/TDD: (877) 652-1844 (*toll-free*) or writing PO Box 91110, Sioux Falls, SD 57109-1110.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-868-1019, 800-537-7697 (TDD).

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

Limitation Period for Filing Suit

In the Preface, the following physical address is amended as follows:

Physical Address

Sanford Health Plan
1749 38th St. S.,
Fargo ND 58103

Member Services

(701) 417-6500 or (800) 499-3416 (*toll-free*) or
TTY/TDD: (877) 652-1844 (*toll-free*)

Notice of Privacy Practices

In the Preface, the following change has been made:

This Notice applies to Sanford Health Plan. If you have questions about this Notice, please contact Member Services at (800) 499-3416 (*toll-free*) | TTY/TDD (877) 652-1844 (*toll-free*).

Member Rights

In the Introduction Section, the subsection, *Member Rights* has been expanded to include the following:

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

1. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; national origin; *color*; gender; *gender identity*; age; *sex*; sexual orientation; medical condition, including current or past history of a mental health and/or substance use disorder; disability; religious beliefs; or sources of payment for care.

Eligibility Requirements for Dependents

Section 3, Enrollment, subsection, *Eligibility Requirements for Dependents*, is revised. The Plan covers has expanded its definition of a disabled dependent to include the following.

The following Dependents are eligible for coverage (“Dependent coverage”):

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

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

1. Be your natural child, a child placed with you for adoption, a legally adopted child, a child for whom you have legal guardianship, a stepchild, or foster child; and
2. Be one of the following:
 - a. under age twenty-six (26); or
 - b. incapable of self-sustaining employment by reason of a disabling condition and chiefly dependent upon the Certificate holder/Subscriber for support and maintenance. If the Plan so requests, the Subscriber must provide proof of the child’s disability within *thirty-one (31)* days of the Plan’s request. Such a request may be no more than annually following the two year period of the disabled dependent child’s attainment of the limiting age [N.D.C.C. §26.1-36-22 (4)]. If a person has a disabled dependent that is over the limiting age but was never previously covered by the Plan, they are eligible for coverage if the disability occurred prior to reaching the limiting age of 26. *If for any reason, Subscriber drops coverage for a disabled dependent prior to age 26, then wishes to cover the child again, coverage must be added prior to the child turning age 26. If the disabled child has reached age 26, the child must be continuously covered under the Plan in order to maintain eligibility.*

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

Dependent of Dependent Child - To be eligible for coverage, a dependent of the Subscriber’s Dependent child, as defined above, must meet all the following requirements:

3. Be the natural child of the Subscriber’s Dependent child, a child placed with the Subscriber’s Dependent child for adoption, a legally adopted child by the Subscriber’s Dependent child, a child for whom the Subscriber’s Dependent child has legal guardianship, a stepchild of the Subscriber’s Dependent child, or foster child of the Subscriber’s Dependent child. These same definitions apply to dependents of the Dependent child(ren) of the Subscriber’s living, covered Spouse; and
4. The Subscriber’s Dependent child must be a Covered Dependent under this Certificate of Coverage for the dependent of the Dependent child to be eligible; and
5. The dependent of Subscriber’s Dependent child must be chiefly dependent on the Subscriber’s Dependent child for support.

Telehealth, e-visit, and video visits benefit

In Section 5(a), the following is added:

Telehealth, e-visit, and video visits benefit

Per Plan guidelines (*available upon request*), telemedicine, e-visit, and video visit services are covered and available through secured interactive audio, video, or email connections.

- Access to services may be done through a smart phone, tablet or computer.
- For non-emergency health issues, coverage under this section includes but is not limited to diagnosis, consultation, or treatment.
- Telemedicine, e-visit, and video visit services must be rendered by a Sanford Health Plan-approved Provider and/or Practitioner.

The following services are covered pursuant to the Plan’s medical coverage guidelines:

- **Telemedicine Services:** live, interactive audio and visual transmissions of a physician-patient encounter from one site to another, using telecommunication technologies. Services may include tele-monitoring of patient status and transmittal of the information to another Provider.
- **E-visits:** email, online medical evaluations where providers interact with members through a secured email portal.
- **Video Visits:** virtual visits where providers interact with members using online means; access points may include mobile smart phones; tablets; or computers.

NOTE: Charges for telehealth, e-visit, and video visit services may be subject to deductible/coinsurance; see your SBC for details. Cost sharing for these services does not include any related pharmacy charges. Prescriptions (if any) are covered separately under the Plan’s prescription drug benefit. Charges for prescribed medication/drugs are listed in your SBC.

Not Covered:

- Transmission fees
- Services for excluded benefits

-
- Services not medically appropriate or necessary
 - Installation or maintenance of any telecommunication devices or systems
 - Provider-initiated e-mail
 - Appointment scheduling
 - A service that would similarly not be charged for in a regular office visit
 - Reminders of scheduled office visits
 - Requests for a referral
 - Consultative message exchanges
 - Clarification of simple instructions
-

Infertility services

Section 5(a), Medical services and supplies provided by health care Practitioners and Providers, is amended to read as follows:

Not Covered:

- *Donor eggs including any donor treatment and retrieval costs, donor sperm, cryopreservation or storage of embryos and unfertilized sperm or eggs; Surrogate pregnancy and delivery; Gestational Carrier pregnancy and delivery; and preimplantation genetic diagnosis testing;*

Other treatment therapies not specified elsewhere

In Section 5(a), Medical services and supplies provided by health care Practitioners and Providers, the following is added:

- Non-Surgical, medically necessary treatment, of Gender Dysphoria (Gender Identity Disorder), including hormone therapy, mental/behavioral services, and laboratory testing to monitor the safety of continuous hormone therapy, per Plan guidelines (available upon request).

Orthotic and prosthetic devices

In Section 5(a), *Medical services and supplies provided by health care Practitioners and Providers*, the following change is made:

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

Durable medical equipment (DME)

In Section 5(a), *Medical services and supplies provided by health care Practitioners and Providers*, the Plan does not cover:

- Custom made orthotics

Prescription drug and diabetes supplies benefits

In Section 5(e), *Prescription drug benefits*, the phone number for Pharmacy Management is now toll-free at (877) 658-9194| TTY/TDD: (877) 652-1844 (*toll-free*).

Calculation of Benefits, Secondary Plan

In Section 9, *Coordination of Benefits*, the following section is added:

Calculation of Benefits, Secondary Plan

If Sanford Health Plan is secondary, it shall reduce its benefits so that the total benefits paid or provided by all plans for any claim or claims are not more than one hundred percent of total allowable expenses. In determining the amount of a claim to be paid by Sanford Health Plan, should the Plan wish to coordinate benefits, it shall calculate the benefits it would have paid in the absence of other insurance and apply that calculated amount to any allowable expense under the Plan that is unpaid by the primary plan. Sanford Health Plan may reduce its payment by any amount that, when combined with the amount paid by the primary plan, exceeds the total allowable expense for that claim.

Coordination of Benefits with Governmental Plans

In Section 9, *Coordination of Benefits*, the following section is added to replace the sections *Coordination of Benefits with Medicare* and *Members with End Stage Renal Disease (ESRD)*:

Coordination of Benefits with Governmental Plans

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

Coordination of Benefits with Medicare

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

When MSP Rules Apply to COB

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

Coordination with Medicare Part D

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

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

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

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

*** NOTE:** *Despite the MSP rules, the law does not force an Eligible Employee to accept coverage under this Plan. If an Eligible Employee, who is entitled to Medicare, refuses coverage under this Plan, Medicare will be the primary payer. In this situation, the Plan does not (and is not allowed to) provide coverage for any benefits to supplement the individual's Medicare benefits.*
3. When the Plan is the primary payer for a Member's claims:
 - a. If you're under 65 and disabled, and have coverage under this Plan based on your or a family member's current employment
 - b. When coverage under the Plan is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA)
 - c. The Member (actively-working Employee) is enrolled in Medicare because they are age 65 or older.
 - d. A Covered Spouse, who is enrolled in Medicare because they are age 65 or older, regardless of the age of the Member/Employee.

NOTE: The Member's claim is filed with us by the hospital or doctor. After the claim is processed, we send the Member an Explanation of Benefits (EOB) outlining the charges that were covered. We also notify the health care professionals of the covered charges. If there are remaining charges covered by Medicare, the health care professional may file a claim with Medicare. If the professional will not do so, the Member can file the claim with Medicare. Members may contact their local Social Security office to find out where and how to file claims with the appropriate "Medicare intermediary" (a private insurance company that processes Medicare claims).
4. If a Practitioner and/or Provider has accepted assignment of Medicare, Sanford Health Plan determines allowable expenses based upon the amount allowed by Medicare. Sanford Health Plan's allowable expense is the Medicare allowable amount. Sanford Health Plan pays the difference between what Medicare pays and Sanford Health Plan's allowable expense.
5. Employees who reach age 65 and are still employed at Sanford may remain covered under the Sanford Health Plan. Sanford Health Plan will remain the primary carrier and Medicare will be the secondary carrier. When the Spouse of an Employee reaches the age of 65, they will have the option of selecting Sanford Health Plan or Medicare as their primary insurance carrier.

Members with End Stage Renal Disease (ESRD)

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

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

How Primary vs. Secondary is Determined:

1. When the Plan is the primary payer for a Member's claims under ESRD:
 - a. The Plan will pay first for the first 30 months after you become eligible to join Medicare.
 - b. During the Medicare coordination period of thirty (30) months, which begins with the earlier of:
 - i. The month in which a regular course of renal dialysis is initiated; or
 - ii. In the case of an individual who receives a kidney transplant, the first month in which the individual became entitled to Medicare.
 - iii. The Medicare COB period applies regardless of whether coverage under the Plan is based on current employment status.
 - c. After the 30-month period, if a Member does not enroll in, or is no longer eligible for, Medicare.
 - d. When coverage under the Plan is provided through the Consolidated Omnibus Budget Reconciliation Act (COBRA), or a retirement plan.
2. When Medicare is the primary payer for a Member's claims under ESRD:
 - a. If the Member is eligible and enrolled in Medicare, Medicare will pay first after the coordination period for ESRD (30-months) has ended period.

Coordination of Benefits with Medicaid

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

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

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

Coordination of Benefits with TRICARE

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

1. This Plan pays first if an individual is covered by both TRICARE and this Plan, as either the Member or Member's Dependent; and a particular treatment or procedure is covered under both benefit plans.
2. TRICARE will pay last; TRICARE benefits may not be extended until all other double coverage plans have adjudicated the claim.
3. When a TRICARE beneficiary is covered under this Plan, and also entitled to either Medicare or Medicaid, this Plan will be the primary payer, Medicare/Medicaid will be secondary, and TRICARE will be tertiary (last).
4. TRICARE-eligible employees and beneficiaries receive primary coverage under this Plan's provisions in the same manner, and to the same extent, as similarly situated employees of the Plan Sponsor (Employer) who are not TRICARE eligible.

Sanford Health Plan does not:

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

Subrogation of Right of Reimbursement

In Section 13, *Subrogation of Right of Reimbursement*, the following section is added as a replacement to the previous section:

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

This Plan may give or obtain needed information from another insurer or any other organization or person. Each and every Covered Individual hereby authorizes the Plan to give or obtain any medical or other personal information reasonably necessary to apply the provisions of Sections 11 and 12.

A Covered Individual will give this Plan the information it asks for about other plans and their payment of Allowable Charges. The Health Plan has a right to reduce benefits, or to be reimbursed for that which it has provided to the Member. This is called "Reimbursement" and this part of the Policy covers such situations.

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

Plan's Rights of Subrogation

In the event of any payments for benefits provided to a Member under this Plan, the Plan, to the extent of such payment, shall be subrogated to all rights of recovery such Member, Member's parents, heirs, guardians, executors, or other representatives may have against any person or organization. These subrogation and reimbursement rights also include the right to recover from uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, automobile medical payments coverage, premises medical expense coverage, and Workers' Compensation insurance or substitute coverage.

The Plan shall be entitled to receive from any such recovery an amount up to the Reasonable Cost for the services provided by the Plan. In providing benefits to a Member, Sanford Health Plan may obtain discounts from its health care Providers, compensate Providers on a capitated basis or enter into other arrangements under which it pays to another less than the Reasonable Costs of the benefits provided to the Member. Regardless of any such arrangement, when a Member receives a benefit under the Plan for an illness or injury, the Plan is subrogated to the Member's right to recover the Reasonable Costs of the benefits it provides on account of such illness or injury, even if those Reasonable Costs exceed the amount paid by the Plan.

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

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

Plan's Right to Reduction and Reimbursement

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

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

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

Erroneous Payments

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

Member's Responsibilities

1. The Member, Member's parents, heirs, guardians, executors, or other representatives must take such action, furnish such information and assistance, and execute such instruments as the Plan requires to facilitate enforcement of its rights under this Part. The Member shall take no action prejudicing the rights and interests of the Plan under this provision.
2. Neither a Member nor Member's attorney or other representative is authorized to accept subrogation or reimbursement payments on behalf of the Plan, to negotiate or compromise the Plan's subrogation or reimbursement claim, or to release any right of recovery or reimbursement without the Plan's express written consent.
3. Any Member who fails to cooperate in the Plan's administration of this Part shall be responsible for the Reasonable Cost for services subject to this section and any legal costs incurred by the Plan to enforce its rights under this section. The Plan shall have no obligation whatsoever to pay medical benefits to a Covered Individual if a Covered Individual refuses to cooperate with the Plan's Subrogation and Refund rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its Subrogation and Refund rights. Further, in the event the Covered Individual is a minor, the Plan shall have no obligation to pay any medical benefits incurred on account of injury or illness caused by a Third Party until after the Covered Individual or his or her authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first-dollar Subrogation and Refund rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.
4. Members must also report any recoveries from insurance companies or other persons or organizations arising from or relating to an act or omission that caused or contributed to an injury or illness to the Member paid for by the Plan. Failure to comply will entitle the Plan to withhold benefits, services, payments, or credits due under the Plan.

Separation of Funds

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

Payment in Error

If for any reason we make payment under this Certificate of Coverage in error, we may recover the amount we paid.

Free Help in Other Languages

The following section has been added to the beginning of every Certificate of Coverage:

Free Help in Other Languages

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

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

For help in a language other than English, please call us toll-free at (800) 892-0675. Both oral and written translation services are available for free in at least 150 languages.

English

This Notice has Important Information. This notice has important information about your application or coverage through Sanford Health Plan. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-800-752-5863 (toll-free) | TTY/TDD: 1-877-652-1844 (*toll-free*). For assistance in a language other than English, call 1-800-892-0675 (toll-free).

Spanish

Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Sanford Health Plan. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-892-0675.

German

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Sanford Health Plan. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-892-0675.

Chinese

本通知有重要的訊息。 本通知有關於您透過 插入 Sanford Health Plan 項目的名稱 Sanford Health Plan 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入數字 1-800-892-0675]。

Cushite

Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisni kun sagantaa yookan karaa Sanford Health Plan tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkooፊsa bilbilaa 1-800-892-0675 tii bilbilaa.

Vietnamese

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Sanford Health Plan. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-892-0675.

Bantu

Iyi notice ifise akamaro k'ingenzi. Iyi notice ifise akamaro kingene utegerezwa gusaba canke ivyerekeye Sanford Health Plan, ucuraba ko ibikenewe kuriyi notice, ushobora gufata umwanzuro ukungene wokurikirana ubuzima bwawe uburihiye. Kandi ukongera kugira uburenganzira bwo kwigena kuronka amakuru n'ubufasha mu rurimi gwawe atacyo utanze. Hamagara 1-800-892-0675.

Arabic

تماه تاملوعم راعشلا اذه يوحي. للاخ نم تبطغلا بلع لوصحلل كيلط صوصخب مهم تاملوعم راعشلا اذه يوحي Sanford Health Plan. راعشلا اذه يف تماهلا خير او تالاع ثحبا عفد يف تدعاسملل و ا قحصلا كتبطغت بلع ظافلل قديم خير او ت يف ءارجا داختلا جاتحت دق فيلاكتلا. فلكت يا نود نم كتغلب تدعاسملاو تاملوعملا بلع روصحلا يف قحلا كل. ب لصتا 1-800-892-0675.

Swahili

Ilani hii ina Taarifa Muhimu. Ilani hii ina taarifa muhimu kuhusu maombi yako au chanjo kupitia Sanford Health Plan. Angalia kwa ajili ya tarehe muhimu katika ilani hii. Waweza pia hitajika kuchukua hatua katika muda ulio pangwa fulani ili uweze ku hifadhi bima yako ya afya au msaada wa gharama zake. Una haki ya kupata habari hii na msaada kwa lugha yako bila gharama. Piga nambari hii: 1-800-892-0675.

Russian

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Sanford Health Plan. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-800-892-0675.

Japanese

この通知には重要な情報が含まれています。この通知には、Sanford Health Plan の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1-800-892-0675までお電話ください。

Nepali

यो सूचनामा महत्त्वपूर्ण जानकारी छ । यो सूचनामा तपाईंको आवेदिनी वा Sanford Health Plan का माध्यमबाट प्राप्त हुने सुदवािवारे महत्त्वपूर्ण जानकारी छ । यो सूचनामा भएका महत्त्वपूर्ण दमदतहरू ख्याल िनुहुोस् । तपाईंले पाइरहेको स्वास्थ्य दबमा पाइरहन वा तपाईंको खचुको भुक्तानीमा सहायता पाउन केही समय-सीमामा काम-कारवाही िनुपने हुनसक्छ । तपाईंले यो जानकारी र सहायता आफ्नो मातृभाषामा दनःशुल्क पाउनु तपाईंको अधिकार हो । 1-800-892-0675 मा फोन िनुहुोस् ।

French

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Sanford Health Plan. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-800-892-0675.

Korean

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Sanford Health Plan 을 통한 커버리지에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-892-0675 로 전화하십시오.

Tagalog

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Sanford Health Plan. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan o tulong na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-892-0675.

Norwegian

Denne kunngjøringen har viktig informasjon. Kunngjøringen inneholder viktig informasjon om programmet eller dekning gjennom Sanford Health Plan. Se etter viktige datoer i denne kunngjøringen. Du må kanskje ta affære ved visse frister for å beholde helsedekning eller økonomisk bistand. Du har rett til å få denne informasjonen og hjelp i ditt språk uten kostnad. Ring 1-800-892-0675.

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