



Client Manual
Group Medical & Prescription
Drug Coverage

SANFORD[®]
HEALTH PLAN

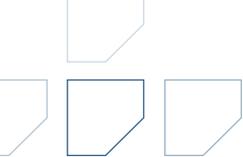




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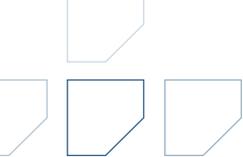
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Welcome to Sanford Health Plan!

Dear valued client,

Welcome to our integrated system of health care coverage. As an employer, we understand that health insurance is one of the largest expenses for your business, and we thank you for selecting Sanford Health Plan.

Keeping employees healthy, before they become ill or injured, is central to our philosophy. We offer numerous opportunities designed to maintain healthy lifestyles by promoting education, prevention and early detection of health conditions. Together, we can work toward our mutual objective of maintaining optimum health for you and your employees.

Thank you again for choosing Sanford Health Plan.

Kirk Zimmer
Executive Vice President
Sanford Health Plan





EXECUTIVE SUMMARY

Integrated services

With Sanford Health Plan, you gain a partner and advocate. We align you and your employees with our providers to deliver a patient-centered health plan that meets your needs.

Our network includes expert providers across South Dakota, Iowa, North Dakota and Minnesota with access to additional providers nationwide.

Value

We recognize that in order to reduce costs, physicians and hospitals require a payment system that is based on value (quality and cost) rather than volume. Sanford Health Plan has developed custom provider methodologies with Sanford Health that define performance by quality measures.

Sanford Health Plan is committed to accomplishing the following goals:

- Manage health care costs to maintain affordable premiums
- Provide full data transparency and analysis of utilization, quality of care, efficiency, and comparative provider cost and utilization data
- Develop and deliver information in formats that are useful in planning and decision making
- Educate and inform employees to become engaged health care consumers
- Prompt and accurate claims processing
- Offer superior customer service
- Provide web-based tools to HR staff and employees that assist in eligibility, benefit experience review and claims management

Client services

Each client is assigned a representative within our Sanford Health Plan Client Services team. This representative serves as the client liaison, funneling all the necessary information from your office back to our internal teams. This results in quick, correct and direct answers to questions. We also help with:

- Complex issues or concerns
- Coordinating and assisting with open enrollment meetings
- Managing your renewal, coordinating benefit package design and consulting services
- Reviewing your client reporting package with you, to help you understand the financial health of your insurance benefit plan
- Assisting with regulatory questions and compliance
- Participating in company-sponsored health and wellness fairs

Client satisfaction is measured by monitoring both client and member concerns. These concerns are monitored by reviewing network adequacy, appeals and grievances, and comments from new member satisfaction surveys. Sanford Health Plan follows the standards of the National Committee for Quality Assurance (NCQA).

We also strive to keep abreast of policy changes and other federal and state regulations affecting insurance benefit plans. We communicate as quickly and effectively as possible in order to keep our clients informed and able to understand the complex issues of today's rules and regulations affecting their health insurance.

ONLINE SERVICE & SUPPORT

For you

Sanford Health Plan offers a secure online portal just for you. With *mySanfordHealthPlan* you get convenient, secure and efficient access to the important information you need to manage your organization.

- ✓ View member eligibility
- ✓ Access member benefit information (including SBC)
- ✓ Request replacement ID cards
- ✓ Access and print forms
- ✓ View other resources and educational information
- ✓ Contact client services via secure messaging

Follow these simple steps to create your account:

1. Go to sanfordhealthplan.com, click on "Login" in the upper right corner and select "Employer".
2. Click on "Create an Account"
3. "Agree" to the License Agreement, provide requested information and click "Finish", then click "here" to proceed to secure site.
4. Click on "Request Employer Services Approval" and "Request Approval", then "Request Online Access".
5. After you click "Submit", you are registered. Once approved, you will receive a notification by email.

For your employees

Once members receive their ID card, they can sign up for a secure member account.

Your employees will then have access to:

- ✓ Provider and pharmacy directories
- ✓ Find the cost or coverage of a medication
- ✓ Replacement ID cards or report lost/stolen ID card
- ✓ Send secure email to customer service
- ✓ Deductible and out-of-pocket balances
- ✓ Recent claims
- ✓ Connect to their flex spending account or health savings account
- ✓ Policy and Summary of Benefits & Coverage (SBC)
- ✓ Preventive care guidelines
- ✓ Online Wellness Portal

Mobile app keyword search: Sanford Health Plan

Contact us

Customer service representatives are available from 8 a.m. to 5 p.m. CST Monday through Friday. A confidential voicemail is available after hours and during the weekend. Calls are returned within one business day. All phone calls and electronic contact (i.e. email) are logged and recorded.

Department	Services Provided	Phone Number
Client services	Forms, supplies or general inquiries	(605) 328-6803
Enrollment/eligibility	Additions, changes, termination in coverage (status of processing), COBRA inquiries, etc.	(605) 328-6886
Customer service	Claim inquiries, coordination of benefits, order ID cards, benefit questions, complaints/appeals	(800) 752-5863
Flexible spending department	FSA, HSA or HRA accounts	(877) 737-7730
Utilization management	Prior authorization, complex case management, referrals, medical necessity determinations, transplant services, healthy pregnancy program or disease management programs	(800) 805-7938
Pharmacy department	Drug formulary or prescription questions	(855) 305-5062
Finance/billing	Premium invoice or payment inquiries	(605) 328-6830
Language line	Help for non-English speaking members	(800) 892-0675
My Sanford Nurse	Health questions or information on appropriate level of care, 24-hours, 7-days-a-week	(888) 315-0886

Holiday Closings: New Year's Day, Memorial Day, Independence Day, Labor Day, Thanksgiving Day, Christmas Day

ENROLLMENT

Electronic Enrollment

- **myEnrollment online portal**
Sanford Health Plan offers a secure, easy-to-use enrollment portal that allows you and/or your employees to enroll in their health insurance benefits electronically. If used by your employees, our online enrollment portal offers a unique shopping experience. If you offer more than three deductible plans, the system offers sophisticated decision support tools while enrolling through the system. The online portal also connects to the provider directory, so that the employee can ensure that their provider is in-network for the plan they are selecting. Paper applications are not accepted when using this portal.
- **Using an outside enrollment vendor**
Sanford Health Plan accepts ANSI X12N 834 benefit and enrollment maintenance transactions when submitted in compliance with our 834 companion guide (available online and by request). Contact your account executive or the client services department for this option.

Paper applications

Paper applications, if not using an online enrollment portal, can be completed and securely emailed to SHPenroll@sanfordhealth.org. Sanford Health Plan requires that original forms be sent to our office within 31 days of all enrollment events. Full audit procedures assure that member information is entered timely, completely and accurately.

Member eligibility is reviewed as per the Employer Application. All enrollment records are maintained for seven (7) years. **IMPORTANT** – If you are submitting a paper application, complete the shaded box at the top of the form. Incomplete forms will be returned. If the employee waives coverage, you do not need to send us the form, however we recommend that you keep it for your files.

Enrollment guidelines

IMPORTANT – New enrollments, terminations, and other types of enrollment changes must be submitted to Sanford Health Plan **within 31 days of the event**.

New enrollments

New enrollments will occur from the following events:

- New hires electing coverage
- Existing employees electing coverage due to a qualified family status change (see list of qualifying events under enrollment changes section)
- Existing employees electing coverage during annual open enrollment period

The employer is responsible for giving the employee a new hire booklet. This ensures that the new employee has all the information necessary to enroll in Sanford Health Plan.

- If the employee is electing coverage, an enrollment application (or other form of electronic enrollment) must be completed.
- Once the enrollment application (or other form of electronic enrollment) is completed by the employee, the employer must complete the shaded box at the top in its entirety and send it to Sanford Health Plan within 31 days of the enrollment event.
- Sanford Health Plan will process the application within three to five business days of receipt.
- ID cards for the employee and any enrolled dependents will be mailed to the employee's home address.

Qualified Life Events

Once enrolled, a member cannot change his or her health insurance election unless they have a qualifying event. Examples of qualifying events include:

Change in family status affecting a member such as:

- Marriage or divorce
- Annulment
- Death of a spouse or dependent child
- Birth or adoption of a child
- Loss of dependent status (a child reaches the age limit under the plan or is no longer eligible as a dependent)

Change in employment status affecting benefits such as:

- Beginning or returning from an unpaid leave of absence
- Sabbatical
- Change in employment status affecting benefits

Change in member spouse's employment status causing a gain or a loss of health coverage for the member or their dependents:

- Beginning or ending employment
- Increasing or decreasing hours
- Strike or lockout
- Open enrollment

Changes associated with a spouse's open enrollment period including changes in the type and cost of coverage:

- Gain or loss of eligibility for Medicare/Medicaid for member, their spouse or child

If a member has a qualifying event, the change made to the plan must be consistent with and appropriate for the new circumstances. See examples below*:

Event	Timeframe	Change takes effect
Birth/adoption of a child	Child must be added within 31 days of the birth/adoption	Date of the birth or adoption
Spouse loses his/her job	Spouse must be added within 31 days of event	First of month that coincides with or following the qualifying event
A dependent child attains the limiting age	Coverage is terminated the end of the dependent's birth month	Coverage ends the last date of the dependent's birth month
Change of marital status	Add/delete dependents within 31 days of the event, based on the situation	First of month that coincides with or following the qualifying event
Spouse has open enrollment	Add/delete dependents within 31 days of the event, based on the situation	First of month that coincides with or following the qualifying event

**This is only a summary; please refer to plan documents for full details.*

Enrollment changes/terminations

If you are filing paper enrollment changes, use the enrollment change form for the following events:

- Name change
- Address change
- Employee's voluntary termination of coverage
- Change in coverage due to qualified family status changes. For example, adding dependents due to marriage, birth/adoption, qualified medical support orders or court orders
- Deleting dependents due to voluntary cancellation of coverage, or death of a dependent
- Change in benefit package during open enrollment (or other authorized event)
- Employee's involuntary loss of eligibility due to:
 - Termination/resignation of employment
 - Reduction in hours which causes a loss in benefits
 - Layoff/strike
 - Leave of absence (medical or non-medical) which causes a loss in benefits
- Dependent's voluntary loss of eligibility for coverage due to:
 - Death of covered employee
 - Divorce/legal separation
 - Child's loss of dependent status
 - No longer full-time student
 - Graduation from college/university
 - Marriage
 - Employee's entitlement to Medicare

The change form must be completed, signed and returned to Sanford Health Plan within 31 days of the event

Electronic – all enrollment transactions (including changes and terminations, must be entered through the appropriate online enrollment portal.)

Paper – forms can be found in your online employer account at www.sanfordhealthplan.com/employerlogin.

Terminations

It is the employer's responsibility to submit termination notices to Sanford Health Plan within 31 days of the termination. Sanford Health Plan will send COBRA notifications, as required, within 14 days of receiving a termination notice from the employer.

ID Cards

Each covered member will get their own insurance ID card and should use it at each provider visit or when filling a prescription. An explanation of the information shown on the card is below for your reference. All members should receive their ID card before their policy is activated.

If an employee has not received their ID card or if it is lost, they can log in to their member portal to print a temporary card or request a new one. You can also log in to your employer portal and request a new ID card for your employee. If your employee needs to visit a doctor, the provider can contact customer service to verify their insurance coverage. If your employee needs to fill a prescription and does not have their ID card, they will have to pay for the medication and submit a paper claim for reimbursement, or return to the pharmacy after obtaining their ID card.

The diagram shows a sample ID card for Sanford Health Plan. Callouts on the left point to the following information:

- Unique identification number:** ID: 12345678910
- Employer group number (if applicable):** Jane A Doe, Grp: XYZ00123456
- Office visit copay amount:** In Network Office Visit: Deductible/coinsurance (Copay) Info Here
- Urgent/Emergent Care Information:** Members: For urgent or emergency care when you are out of the local service area, seek treatment at the nearest medical facility or call 911. Notify Sanford Health Plan of an admission as soon as it is reasonably possible and no later than 48 hours after physically or mentally able to do so. Eligibility: This card is for identification purposes only. It does not constitute proof of eligibility.

Callouts on the right explain:

- ID Card header will vary based on your plan type:** Points to the Sanford Health Plan logo.
- If a logo is printed here, you have prescription drug coverage:** Points to the OptumRx logo.

- (A) Call this number for any questions about your benefits
- (B) Pre-approval phone number for medical and pharmacy services. You must get pre-approval of outpatient or inpatient procedures or admissions, anesthesia, home health care, medical equipment, cancer services and treatment, genetic testing, transplants and specialty medication.
- (C) Information for your pharmacy (if you have pharmacy coverage)
- (D) If a logo is printed here, you may have coverage outside the service area. See your plan documents for details.

The diagram shows a card with the following information:

- View Provider Directory at:** sanfordhealthplan.com
- Customer Service:** 1-800-752-5863 or (605) 328-6800 (A)
- Pre-certification/authorization:**
 - Medical:** 1-800-805-7938
 - Pharmacy:** 1-855-305-5062 (B)
 - OptumRX (Pharmacy use only):** 1-866-833-3463 (C)
- Payor ID:** 91184
- Submit claims to:** Sanford Health Plan*, PO Box 91110, Sioux Falls, SD 57109-1110
- Logos:** PHCS Health Directions and MultiPlan complementary network (D)

The networks above are only available to members residing, traveling or attending school outside the Sanford Health Plan service area.

PROVIDER NETWORKS

Broad Network

Consists of over 24,000 providers within the Dakotas, Minnesota and Iowa. The network expands beyond the Sanford Health care system, including access to Multiplan's nationwide networks for urgent and emergent coverage while traveling or for members residing outside the Sanford Health Plan service area.

Focused Network

Consists of providers in our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota and Iowa.

To receive benefits, members will need to see providers listed in this directory. For more information about benefits, contact Customer Service.

Tiered Network

Sanford Health Plan's Broad network is grouped into two tiers. Member's cost share is based on the tier of the provider from whom they receive care. Tier 1 (lowest member cost-share) includes our large care system of Sanford Health providers and facilities. Tier 2 (higher member cost-share) includes the broad network that expands beyond the Sanford Health system, including access to Multiplan's nationwide networks for urgent and emergent coverage while traveling or for members residing outside the Sanford Health Plan service area.

To receive the highest level of benefits, members will need to see providers listed in this directory. For more information about benefits, contact Customer Service.

New or terminated providers

Updated weekly, newly contracted or newly terminated providers are added or removed from our online provider directory.

Members who have seen a terminated provider within the prior 12 months are notified via letter that their provider is no longer part of the network. The letter includes alternate providers for the member to transition his or her care to, and our nurse case managers assist to ensure a smooth transition.

Nominating a provider

On occasion, there may be a member seeking services from a provider or facility currently not in the Sanford Health Plan network. In this event, the employee can complete a provider nomination form, located on the provider directory.

Although we cannot guarantee the providers participation, we will contact the provider for participation in our network.

Providers outside service area

Members who need services, which are considered urgent or emergent, can seek care at any provider. However, if members are referred to out of network providers, members may need pre-approval BEFORE they receive care. This includes facilities such as Mayo Clinic. Some plans do not offer out of network coverage, so members are encouraged to check their plan documents before receiving services outside the network.

A national network is available to those members living or residing outside the Sanford Health Plan service area.



Providers in other countries

For members incurring medical or pharmacy services outside the country, the member should pay for the services, then complete and send Sanford Health Plan a medical or pharmacy claim form. Forms can be found online at www.sanfordhealthplan.com/memberlogin.

Transplant network

For transplant needs, Sanford Health Plan members must use a “Center of Excellence” transplant center. All transplants must be authorized by calling our Utilization Management team.

CLAIMS ADMINISTRATION

Claims processing

Benefits are configured based on the policy (certificate of insurance) and the summary of benefits and coverage. Through the claims processing system, edits are configured to check for duplicate claims and to automatically link authorizations for procedures that require pre-certification. The claims system also utilizes an algorithm of edits that are configured to determine potential mismatches for diagnosis/procedure codes, age, specialty of provider, etc. Sanford Health Plan processes all medical claims internally and is not outsourced. Claims are repriced according to the provider contracts. Covered members using in-network providers will experience savings between the billed and allowed amounts per claim.

Auto adjudication

Sanford Health Plan processes approximately 94 percent of its claims electronically and accepts inbound professional, institutional and dental 5010 ASC X12 837s. For EDI claims data, we support the 837I, 837P, and 837D batch transactions.

Explanation of Benefits (EOB)

Once claims are processed, Sanford Health Plan will communicate, either electronically or by paper, how the claim was processed. This is called an “Explanation of Benefit.”

A Your benefit information at your fingertips, anytime, anywhere!
mySanfordHealthPlan, your personalized tool, found at sanfordhealthplan.com, allows you to:

- View your claims and deductible status
- Find a provider or pharmacy
- View your ID card

Explanation of Benefits – This is NOT a Bill

Member#: 11122233301 Claim#: 123456		Member Name: Jane Doe				Provider: 1234567892, Provider John Vendor: Sanford Clinic				
Service Date	*Description	Amount Billed	Discount Amount	Non-Covered Amount	Reason Codes	Allowed Amount	Copy	Deductible	Co-insurance	Amount Paid
B	C	D	E	F	G	H	I	J	K	L
02/01/17	73 Diagnostic service, charges applied to deductible	\$117.00	\$70.49	\$0.00		\$46.51 <small>\$117.00 - \$70.49 = \$46.51</small>	\$0.00 <small>No copy was due for this service</small>	\$46.51 <small>Allowed amount applied to deductible</small>	\$0.00 <small>No coinsurance due, deductible has not been met</small>	\$0.00 <small>Plan does not pay until your deductible has been met</small>
02/15/17	98 Office visit, copay applies	\$226.00	\$70.31	\$0.00		\$155.69 <small>\$226.00 - \$70.31 = \$155.69</small>	\$20.00 <small>Copay due for office visit</small>	\$0.00 <small>Service not diagnostic, deductible does not apply</small>	\$0.00 <small>Not applicable, service only requires copay</small>	\$135.69 <small>Allowed amount paid</small>
		\$343.00	\$211.29	\$0.00		\$248.71	\$20.00	\$46.51	\$0.00	\$135.69

C *Description/Messages
 73 DIAGNOSIS MEDICAL
 98 PROFESSIONAL (PHYSICIAN) VISIT - OFFICE

M **Total member responsibility: \$66.51**
 The member owes \$46.51 for 2/1/17 service (applied to deductible) and a \$20.00 copay for 2/15/17 service. [Copays do not go toward your deductible or out of pocket maximum.]

- A** Information and messages can be found here.
- B** The date you received medical care.
- C** Type(s) of services or products you received from your provider. See the “*Description/Messages” information after the claim information to determine the type of service.
- D** The full amount billed to Sanford Health Plan by your provider.
- E** Amount you saved by using an in-network provider (if applicable). Sanford Health Plan negotiates lower rates with its in-network providers to help you save money.
- F** The portion of the amount billed that was not covered or eligible for payment under your plan. Examples may include charges for excluded services or not getting a pre-approval for a service.
- G** Explains why a claim was denied (if applicable).
- H** The amount Sanford Health Plan has agreed to pay the provider for the service or product.
- I** A set amount you pay for certain covered services such as an office visit. Usually paid at the time of service.
- J** Applied to the amount you must pay for covered services before Sanford Health Plan starts to pay.
- K** A percentage of covered expenses that you pay after you meet your deductible, for example 20%.
- L** The amount Sanford Health Plan has paid to the provider per your benefit plan for your care.
- M** Total amount due to the provider based on columns I, J and K.



Coordination of benefits

The system allows all necessary coordination of benefits (COB) information to be recorded on an individual member basis. The other coverage carrier, type of carrier, effective date, policy number termination date or reason, entitlement (for Medicare), and COB order is stored for each member with other coverage. Members, including both active and COBRA, claims are put on a hold status until Sanford Health Plan has completed verification of other coverage.

Subrogation claims review – Work-related injuries

Sanford Health Plan's policy is to pay and pursue. We contract with Optum to review and investigate possible work-related or third-party liability claims. A daily secure data file is sent to Optum and is based on diagnosis codes that may indicate an injury or possible third-party liability. Optum then performs an investigation to determine if other carrier liability exists by contacting the members via telephone and mail.

High-dollar claims

High dollar claims above \$50,000 are flagged for review by claims examiners and verified before claim payment.

Out-of-area/out-of-country claims

All out-of-area emergency services are processed at the in-network benefit level. Sanford Health Plan utilizes various wrap networks to increase network and discount availability. Claims for services received outside these networks will be processed using the usual and customary reimbursement, as defined by Sanford Health Plan. Medical claim forms can be found in your employer portal at www.sanfordhealthplan.com/employerlogin.

To serve our members living or residing outside our service area, Sanford Health Plan has a direct contract with Multiplan for the PHCS Healthy Directions and Multiplan Complementary national networks.

Physician on staff for review of claims

Sanford Health Plan employs doctors and nurses to review claims for the requirement of medical necessity, review claims that may be experimental in nature, or review a quality of care event.

Audit programs

Internal audits are performed on a monthly basis and 2 percent of all claims are audited, with 100 percent review for claims with dollar amounts over \$50,000.

Appeals

Sanford Health Plan is compliant with the required timeframes and notice requirements for responding to appeals and grievances as required by the Affordable Care Act.

MEDICAL AND PHARMACY MANAGEMENT

Utilization review

The Sanford Health Plan Utilization Department is available for both providers and members for the authorization of certain outpatient and inpatient services. Authorization is necessary to ensure our members receive the appropriate level of care and that the care is medically necessary. Members must authorize the following (not a complete list). The complete list can be found within the secure member portal at www.sanfordhealthplan.com/memberlogin.

Inpatient hospital admissions*	Inpatient and certain outpatient surgeries	Home health services
Hospice	Home IV therapy	Certain durable medical equipment
Skilled nursing and sub-acute	Transplants	Prosthetic limbs
Genetic testing	Certain orthotics/prosthetics	Certain specialty drugs
Bariatric surgery (if covered)	Oncology treatment	Referrals to non-participating providers

*Inpatient stays are verified for reasonable length of stay, as based on Milliman Care Guidelines.

Disease management programs

Sanford Health Plan has developed the following programs to manage our members with chronic medical conditions:

- ✓ Congestive heart failure
- ✓ Diabetes
- ✓ Hypertension
- ✓ Asthma
- ✓ Coronary artery disease

Members that would benefit from these programs are identified through claims data, authorizations, health risk assessment data, case manager, provider referral or by self-referral. These members are sent program information and encouraged to enroll.

Upon enrollment, members receive a health management toolkit and quarterly information specific to their condition. Case managers provide education and care assistance to members with high-risk scores and identify disease specific care gaps. The assistance is provided either with a telephone call or within the Sanford Health system by using secure messaging between the provider or clinic health coach.

Care management programs

Sanford Health Plan offers the following services to our members:

- Coordination of medical and behavioral health services
- Help with understanding their treatment plan
- Provide support for healthier living
- Help to develop partnerships with providers
- Connection to community resources

This team includes RN and behavioral health care managers that work closely with other health care staff and give the highest level of privacy for each member.

Complex case management

Complex case management (CCM) provides coordination of care and services to members who have experienced a catastrophic event, have multiple chronic illness and/or chronic illness that result in high utilization.

Our nursing staff is available to assist members in regaining optimum health or improved functional capability. The nurses monitor care to ensure that treatment plans align with evidence-based clinical standards, to close care gaps and to ensure members are appropriately using health care resources in a cost-effective manner.

Quality improvement program

Sanford Health Plan and its participating providers acknowledge their responsibility to provide high-quality care in a cost-effective manner through ongoing monitoring, evaluation and improvement process. Through the commitment of the Sanford Health Plan Board of Directors and Physician Quality Committee, we are able to develop and carry out a quality assurance plan that has a systematic approach to assessing, measuring, defining and resolving medical care, behavioral health, and service issues.

Prescription drugs

Sanford Health Plan has developed a model of quality patient care utilizing cost-effective medications established by sound clinical evidence-based medicine. We contract with OptumRx as our pharmacy benefit manager to promote optimal therapeutic use of pharmaceuticals. Together with OptumRx, we produce a formulary; a list of FDA-approved brand name and generic medications chosen by health care providers on our physician quality committee. The medications selected are clinically effective, safe and cost-effective. Members can find our formulary at www.sanfordhealthplan.com.

Enrolled members must fill prescriptions from pharmacies contracted with OptumRx, which includes national chain pharmacies such as WalMart. Walgreens is not included in the pharmacy network provided to our members.

Members needing specialty medications should contact our Pharmacy Department for authorization. Members can find information regarding specific medications through their secure member account at www.sanfordhealthplan.com/memberlogin.

Sanford Health Plan also offers a \$5 preventive drug benefit to our large employers who offer an HSA Qualified High Deductible Health Plan to their employees. Members who are enrolled in the HSA Qualified High Deductible Health Plan are eligible for this benefit.



VALUE ADDED SERVICES

Fitness center reimbursement

This benefit includes a \$20 monthly (\$40 monthly maximum) reimbursement for the insured employee and insured spouse each month they use the gym 12 or more times. The gym must be a participating fitness facility in the NIHCA organization found at nihcarewards.org.

Digital care/telemedicine services

Virtual care services are offered to all Sanford Health Plan members, including video visits and e-visits. Members can see expert providers for acute, non-emergent primary care needs. Video visits and e-visits are free if a Sanford Health provider is utilized (exceptions apply). Members can visit www.sanfordhealthplan.com/virtualcare to access the virtual care portal with Sanford Health.

COBRA administration

Sanford Health Plan provides complete COBRA administration services at no additional cost. COBRA is administered in-house with the use of Travis COBRA Software, which provides initial notifications, premium rate computations, election forms, unavailability notices, certificates of creditable coverage, rate change notifications, termination notifications, conversion rights notifications, as well as numerous other miscellaneous correspondence. In addition, the general notice is sent to all new members upon enrollment.

Flexible spending accounts

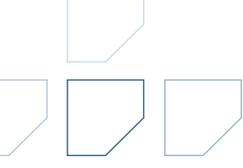
Sanford Health Plan administers both medical and dependent care flexible spending accounts (FSA). These accounts provide a method to offer tax savings for both employers and employees. Employees who enroll in these tax-saving accounts have the opportunity to save on federal and state payroll taxes and increase their take-home pay, allowing employees to pay for certain eligible expenses with pre-tax dollars. Individuals who enroll in the medical FSA accounts are given debit cards, thereby experiencing convenience in paying for eligible medical FSA expenses. Flex participants have the ability to create their own secure online accounts to access balances, file claims, and upload receipts or other documentation that may be required.

Health reimbursement accounts

Sanford Health Plan offers products designed to integrate with a health reimbursement account (HRA). Sanford Health Plan works with employers to develop an HRA plan tailored to meet overall plan design goals. The HRA plan can be structured to reimburse for only non-reimbursed medical expenses covered by the major medical plan, (i.e. deductible), or it can be expanded to include other IRS eligible medical expenses (such as those associated with dental, vision or other qualified expenses). The employer determines HRA fund availability, limits for fund rollover each year, and the disposition of funds when employees are terminated or retire. In addition, the HRA can be stacked with FSA accounts.

Health savings accounts

Sanford Health Plan, in partnership with HealthcareBank, a division of Bell Bank (member FDIC) offers health savings accounts (HSA). Used in conjunction with eligible high-deductible health plans, these savings accounts allow employees to become more responsible for their own health care expenses. The health savings accounts are interest bearing and allow employees to roll unused funds from year to year. They remain owned by the individual, even after a job change. Individuals selecting HSA accounts through Sanford Health Plan will receive debit cards to conveniently pay for their eligible medical expenses.



ADVANTAGE discount cards

Sanford Health Plan, in partnership with Careington International, offers discount cards for dental, hearing, vision, and weight loss programs and services. Employees simply visit the participating provider and present their discount card for reduced prices on the charges for the service. There are no usage limits on services covered by the ADVANTAGE discount card. A listing of providers can be found at careington.com/co/Sanford.

Wellness programs and services

Sanford Health Plan offers wellness program and services to guide and help you create a culture of well-being in your workplace. We can measure your current culture and help rally your team to implement high-impact programs including:

- ✓ Wellness coaching
- ✓ Well-being education
- ✓ Health and well-being screening
- ✓ Other targeted program

All four programs include resources for both leaders and employees to improve the workplace environment and create sustainable and impactful personal behavior changes for your employees.

Contact your client services representative for additional information on any of these value-added services.



BILLING

Monthly premium invoices

Monthly invoices are billed around the 20th of the month.

The invoice will include a list of your employees and their respective premium rate, based on their enrollment tier as appropriate. Invoices are due on the first of the month, as indicated on the invoice (i.e. billed on Jan 20, due Feb 1).

PLAN DOCUMENTS & FORMS

Summary of benefits and coverage

Sanford Health Plan will create and provide a PDF version of this document. It is your responsibility to ensure that a copy is given to each eligible employee.

Policy (certificate of insurance)

Sanford Health Plan will mail a policy to each of your enrolled employees. Members can also view their policy online through their secure mySanfordHealthPlan account.

Enrollment (new hire) booklets

Upon request, Sanford Health Plan will provide new hire enrollment booklets. Contact your client services representative.

Forms

Forms related to health insurance can be found in your employer account at www.sanfordhealthplan.com/employerlogin.



REPORTS

Sanford Health Plan uses data analytics to identify risk and improve outcomes. For our large groups (with 50 or more enrolled employees), we offer a suite of standard reports that give an in-depth overview of the group.

- ✓ Enrollment/demographics
- ✓ Claims paid by enrollment
- ✓ Key cost and utilization metrics
- ✓ Claims expense distribution by paid amounts
- ✓ Predictive high-risk member analysis
- ✓ Common illness/disease conditions utilization summary
- ✓ Case/health management
- ✓ Pharmacy reports
- ✓ Deductible/out of pocket reports
- ✓ Customer service call summary

We are able to provide ad-hoc reports at the client's request with mutually agreed upon timeframes and fees.

YOUR RESPONSIBILITY

Sanford Health Plan is your partner in keeping your health insurance plan compliant. The following information provides you with required disclosures and notices that apply to group health plans subject to ERISA. Sanford Health Plan provides many of these notices to you and your employees. However, you, as an employer, may be required to deliver some items directly to your employees. We have shaded the rows of the documents that are your responsibility. If you have questions regarding your requirements, please contact our clients services department or your account executive.



Document/notice	Applies to	Content summary	Given to	Timing	Provided by	Where to find it
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) Disclosure of Plan Benefits	All group health plans	Description of special enrollment opportunity if eligible for premium assistance under CHIP/Medicaid	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	1. Policy 2. Annual Member Notice 3. Enrollment Booklet (Special Notices)
Notice to Employees of Premium Assistance under Medicaid or CHIP	All group health plans offered in a state with a CHIP or Medicaid program that provides premium assistance for group health plan coverage	Description of special enrollment opportunity if eligible for premium assistance under CHIP/Medicaid, including potential opportunities and instructions on who to contact.	All Employees	On or before an employee is initially offered health insurance enrollment	Employer ¹	Enrollment Booklet (Special Notices)
COBRA Election Notice	All group health plans	Notice to "qualified beneficiaries" of their right to elect COBRA coverage upon occurrence of qualifying event (including other coverage options such as the Marketplace).	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	Mailed directly to member by Sanford Health Plan. Also located in Policy.
Notice of Early Termination of COBRA Coverage	All group health plans	Notice that a qualified beneficiary's COBRA coverage will terminate earlier than the maximum period of coverage.	Any member, as applicable	Upon early termination event	Sanford Health Plan (if COBRA administered)	Mailed directly to member by Sanford Health Plan
Notice of Unavailability of COBRA	All group health plans	Notice that an individual is not entitled to COBRA coverage.	Any member or qualified beneficiary, as applicable	Within 14 days of being notified by the employer that the individual experienced a qualifying event	Sanford Health Plan (if COBRA administered)	Mailed directly to member by Sanford Health Plan
Employer Notice to Employees of Coverage Options	All employers subject to the Fair Labor Standards Act	Written notice informing the employee of the Marketplace, the potential availability of tax credits, and the loss of employer contributions (if applicable) when purchasing insurance on the Marketplace. Model Notice: http://www.dol.gov/ebsa/healthreform/regulations/coverageoptionsnotice.html	All New Employees	Within 14 days of hire	Employer	Model notice indicated in "Content summary"



Document/notice	Applies to	Content summary	Given to	Timing	Provided by	Where to find it
External Review Notices	All group health plans	Independent review organization (IRO), or State office administering external appeals must issue a notice of final external review decision	All enrolled members	Timing varies based on claim type and which state/ federal process	Sanford Health Plan or designee	Mailed directly to member by Sanford Health Plan
External Review Process Disclosure	All group health plans	A description of external review processes	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	1. Policy 2. Enrollment Booklet or Renewal Information (Special Notices)
Family and Medical Leave Act (federal FMLA)	All group health plans, if the employer is subject to the FMLA	Describes eligibility and benefits during a FMLA leave and restoration of benefits upon an FMLA return.	All enrolled members	Upon enrollment in the Plan	Employer	Employer Materials
Genetic Information Non-discrimination Act (GINA)	All group health plans	Upon request for medical information, language must be included to specifically direct the individual or health care provider not to provide genetic information.	All Employees and Eligible Dependents	Upon providing materials describing benefits or health coverage	Sanford Health Plan/ Employer	1. Policy 2. Enrollment Booklet (Member Handbook reference) 3. Wellness Documents (if applicable)
Grandfathered Plan Disclosure/Notice ²	Group health plans claiming grandfathered status	The fact that the plan is grandfathered and includes contact information	All Employees offered coverage	Upon enrollment or renewal in the Plan or when describing benefits/health coverage.	Sanford Health Plan/ Employer	1. Policy 2. SBC 3. Enrollment Booklet or Renewal Packet (Special Notices)
Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Practices for Protected Health Information (PHI)	All group health plans	Privacy practices and disclosures	All enrolled members	Upon enrollment or renewal in the Plan	Sanford Health Plan	1. Policy 2. Member Annual Notice 3. Enrollment Booklet or Renewal Information (Special Notices)
Internal Claims and Appeals Notices	All group health plans	Notice of adverse benefit determination and notice of final internal adverse benefit determination.	All enrolled members	Timing varies based on claim type and federal/state jurisdiction	Sanford Health Plan	1. Policy 2. Enrollment Booklet or Renewal Information (Special Notices) 3. Explanation of Benefits (EOB)
Medicare Part D Annual Notice	All group health plans that provide prescription drug coverage	Discloses to Medicare-eligible Members (employees and their dependents) whether prescription drug coverage offered is "creditable" or "non-creditable" ³	All employees	By October 15 of each year (prior to the Medicare Part D Annual Election) ⁴	Employer	Given to employer via email from Client Services annually in Sept/Oct.
Mental Health Parity and Addiction Equity Act (MHPAEA) Criteria for Medically Necessary Determination	All group health plans	Provides the criteria for medically necessary determinations with respect to mental health/substance use disorder benefits	Any current or potential member, beneficiary, or provider upon request	Within 30 days of request	Sanford Health Plan	Mailed directly to requestor by Sanford Health Plan

Document/notice	Applies to	Content summary	Given to	Timing	Provided by	Where to find it
MHPAEA Claims Denial Notice	All group health plans	Provides the reason for any denial of reimbursement or payment for services with respect to mental health/substance use disorder benefits	Enrolled Member or beneficiary upon request or as required by law	Upon denial and within 30 days of request	Sanford Health Plan	Mailed directly to member by Sanford Health Plan
Michelle's Law Enrollment Notice ⁵	All group health plans	A description of the Michelle's law provision for continued coverage during medically necessary leaves of absence	All enrolled members, as applicable	Included with any notice regarding a requirement for certification of student status for coverage under the plan	Sanford Health Plan	Enrollment Booklet or Renewal Information (Special Notices)
Newborns' and Mothers' Health Protection Act (NMHPA) rights in connection with childbirth	Group health plans that provide maternity or newborn infant coverage	A statement describing requirements under Federal or State law, relating to any hospital length of stay in connection with childbirth for a mother or newborn child.	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	Policy
Notice Regarding Designation of a Primary Care Provider (PCP)	All non-grandfathered group health plans that require Primary Care Provider (PCP) designation	Terms regarding designation of PCP and participants' rights to designate any participating PCP who is available to accept the member.	All enrolled members	Upon enrollment in Applicable Plans	Sanford Health Plan	Policy
Plan Policy	All group health plans	Document/contract between Sanford Health Plan and the Member that informs Members about their plan and how it operates, including their benefits, rights, and obligations under the Plan.	All enrolled members	Sent to all Members within 90 days of enrollment ⁶	Sanford Health Plan	Policy
Preexisting Condition Exclusion Notices and Certificates of Creditable Coverage	All group health plans	As of 01/01/14, preexisting condition exclusions are prohibited. As of 12/31/2014, plans are no longer required to issue certificate of creditable coverage notices.	N/A	N/A	N/A	See 79 Fed. Reg. 10296-317 (Feb. 24, 2014)
Qualified Medical Child Support Order (QMCSO) Notice/ Disclosures	All group health plans	Disclosure of plan's QMCSO procedures	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	Policy
Notice of Special Enrollment Rights	All group health plans	A description of individuals' special enrollment rights.	All employees	At or before an employee is initially offered the opportunity to enroll	Sanford Health Plan	1. Policy 2. Enrollment Booklet or Renewal Information (Special Notices)
Summary of Benefits and Coverage (SBC) and Uniform Glossary	All group health plans	Describes the benefits and coverage under the plan, and a uniform glossary defining required terms.	All enrolled members	Upon enrollment or renewal in the Plan ⁷	Sanford Health Plan or Employer	Enrollment Booklet or Renewal Information
Summary of Benefits and Coverage (SBC) Notice of Modification	All group health plans	Communication of material modification that occurs outside an annual group health renewal.	All enrolled members	At least 60 days prior to effective date	Sanford Health Plan	Mailed directly to member by Sanford Health Plan

Document/notice	Applies to	Content summary	Given to	Timing	Provided by	Where to find it
Transitional Plan Disclosure/Notice ²	Transitional health plans ⁸	Disclosure of continuance of transitional plan and option to enroll in Affordable Care Act compliant plan	Applicable transitional groups	Upon Renewal	Sanford Health Plan	Mailed directly to member by Sanford Health Plan
Uniformed Services Employment and Reemployment Rights Act (USERRA) Notice	All group health plans	Notice of right to elect continuation coverage under USERRA	All enrolled members	Upon enrollment in the Plan	Sanford Health Plan	Policy
Wellness Program Disclosure ⁹	For group health plans offering a health contingent wellness program in order to obtain a reward	Document outlining reasonable alternative standards or methods in which to waive; including contact information and explanation of other accommodation per member's primary care provider.	All eligible participants	Distributed with enrollment materials ¹⁰	Administrator of wellness program	In any plan materials describing terms of health-contingent wellness programs (activity-only & outcome-based)
Women's Health and Cancer Rights Act (WHCRA) Annual Notice	Group health plans that provide coverage for mastectomy benefits	A simplified disclosure regarding benefits of the four required mastectomy related benefits and how to obtain more information.	All enrolled members	Annually to enrolled members	Sanford Health Plan	Annual notice mailed directly to member by Sanford Health Plan
WHCRA Enrollment Notice and Notice of Benefits	Group health plans that provide coverage for mastectomy benefits	A detailed description of applicable annual deductibles/coinsurance limitations and the four required mastectomy related benefits and how to obtain more information.	All enrolled members	Upon enrollment in the plan	Sanford Health Plan	Policy
1095-B Forms	All group health plans	A health insurance tax form which reports the type of coverage a members has and the period of coverage for the prior year. Used to verify attainment of minimum qualifying health insurance coverage.	All enrolled members	Annually to enrolled members	Sanford Health Plan	Mailed directly to member by Sanford Health Plan
1095-C Forms	Applicable Large Employers (ALE) (50 or more full-time employees)	A health insurance tax form which provides information about the health care coverage offered by ALE to report compliance with the employer shared responsibility provisions.	All enrolled members	Annually to enrolled members	Employer	Sanford Health Plan will send necessary data for form completion to Employer each year.

¹**NOTE: the Employer (rather than the group health plan or issuer) is required to provide this notice (29 CFR 2590.701(f)(3)(B)(i)). May be provided with enrollment packets, open season materials, or other materials at or before the time an employee is offered the opportunity to enroll.**

²Under the Affordable Care Act, generally, Grandfathered Plans are plans that were in existence and in which at least one individual was enrolled, on 3/23/10. Transitional Plans are plans that were (1) in effect as of 10/01/13, and (2) have received or would otherwise receive a cancellation or termination notice from the issuer. Grandfathered and Transitional plans are exempt from many but not all Affordable Care Act market reforms.

³NOTE: This requirement is part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA). Employer must notify CMS annually as to whether their prescription drug coverage qualifies as "creditable" or "non-creditable". SHP provides annual memo to Employer on notifying CMS and how employer determines coverage is credible.

⁴Medicare beneficiaries who are not covered under "creditable" prescription drug coverage and who chose not to enroll in a Medicare Part D drug plan when they first became eligible for Medicare or during the initial enrollment period, will likely pay a higher premium permanently if they subsequently enroll in the Medicare Part D drug program (the premium is increased by 1 percent for each month without creditable coverage).

⁵NOTE: Under the Affordable Care Act, plans cannot deny or restrict coverage for a child under the age of 26 based on student status.

⁶Updated document must be furnished every 5 years if changes made to information or plan is amended. Otherwise must be furnished every 10 years.

⁷SBC and a copy of the Uniform Glossary must also be provided upon request within 7 days. SBC must be provided to Special Enrollees no later than the date by which the COC/SPD/Policy Document is required to be provided (90 days from enrollment).

⁸Includes large businesses that currently purchase insurance in the large group market but that, as of 01/01/16, will be redefined by §1304(b) of the ACA as "small businesses" purchasing insurance in the small group market

⁹If the plan materials merely mention that a program is available, without describing its terms, this disclosure is not required.

¹⁰For outcome-based wellness programs, notice must also be included in any disclosure that an individual did not satisfy an initial outcome-based standard.

Legal Disclaimer: This is a general overview based on information currently available. It does not cover all of the requirements, and new information is released frequently. Information and analysis provided by Sanford Health Plan should not be considered legal advice. All information contained herein is for informational purposes only as a service to clients, and is not a substitute for legal counsel. We recommend that you consult with a licensed attorney if you want assurance that the information provided and your interpretation of it are appropriate for your particular situation. The effect of health care reform may differ depending on your circumstances. Sanford Health Plan assumes no liability for the use or interpretation of information contained herein. You should not and are not authorized to rely on analysis provided by Sanford Health Plan as a source of legal or tax advice.



MISCELLANEOUS

HIPAA compliance

Sanford Health Plan is compliant with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and Health Information Technology for Economic Clinical Health (HITECH) regulations, system and record requirements. Sanford Health Plan has a mature security program that features best practices from security standards such as NIST, ISO, and follows the guidelines and specification of the HIPAA security rule.

The Client Services Department, from direction by the policy department, is responsible for coordinating and communicating HIPAA compliant changes to all clients.

Corporate compliance program

Sanford Health Plan maintains a corporate compliance program inclusive of its fraud, waste and abuse detection program. Any report or evidence of actual or suspected violations of the law, regulations, or related standards of conduct shall be forwarded to the compliance officer to determine if the circumstances described may constitute a violation or warrant a more detailed investigation.

Security

Sanford Health Plan's primary eligibility and claim adjudication system is fully integrated with the Sanford EpicCare application. As such, it resides on high availability hardware platforms with secondary implementation sites and automated failover. The primary data center is located at the designated IT building, with the failover data center located on the Sanford USD Medical Center campus. Sanford Health Plan disaster recovery leverages the multiple levels of failover options, which exist to support the 24/7 clinical care applications.



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