North Dakota Medicaid Expansion

Certificate of Coverage

Help understanding this document is free. If you would like it in a different format (for example, in a larger font size or using a screen reader), please call us at (855) 305-5060 (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.
Individual Certificate of Coverage

Renewal Provision
We will refuse renewal of this Certificate of Coverage only if we refuse renewal on all policies of this form and class or if you use this Certificate of Coverage fraudulently. If we refuse to renew all policies of this form and class, we will give you ninety (90) days written notice prior to termination. In this event, you will have the option to purchase any other health insurance currently being offered by us.

How to Contact Us
If you have any questions about provisions of this Certificate of Coverage, please write or call:

Sanford Health Plan
300 Cherapa Place, Suite 201
PO Box 91110
Sioux Falls, SD 57109
Phone: (855) 305-5060 (toll-free)
TTY/TDD: (877) 652-1844 (toll-free)
Translation Services: (800) 892-0675 (toll-free)

Help understanding this document is free. If you would like it in a different format (for example, in a larger font size or using a screen reader), please call us at (855) 305-5060 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free).

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Free Help in Other Languages

This Certificate of Coverage 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 this Plan pays for your care, please call us toll-free at (855) 305-5060 | TTY/TDD: (877) 652-1844.

For free help in a language other than English, please call us toll-free at (800) 892-0675. Both oral and written translation services are available at no charge to Members.

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 1-855-305-5060 (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 | TTY/TDD: 1-877-652-1844.

Chinese

Cushite
Beeksisi kun odeeffannoo barbaachisaa qaba. Beeksistu kunganaa yookan karaa Sanford Health Plan tiin tajaajila keessan ilaalehisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta’an beeksisaa kana keessatti ilaalaa. Tarii kaffaltii haaasha nii yookan tajaajila fayyaa keessaniiuf guyyaa dhumaa irraa irraa dhaan irraa irraa dhaan dhaan dhaan dhaan.

Vietnamese
Thông báo này cung cấp thông tin quan trọng. Thông báo này cung cấp thông tin quan trọng bạn cần bao gồm hướng dẫn, mã số và các thông tin quan trọng khác. Những thông tin này có thể giúp bạn hiểu rõ hơn về quyền lợi của mình.

Bantu

Arabic

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 | TTY/TDD: 1-877-652-1844.

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 | TTY/TDD: 1-877-652-1844までお電話ください。

French

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 위하여 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 무담없이 얻을 수 있는 권리가 있습니다. 1-800-892-0675 | TTY/TDD: 1-877-652-1844로 전화하십시오.

Tagalog

Norwegian
Sanford Health Plan Notice of Privacy Practices

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

This Notice applies to Sanford Health Plan [herein known as “we”/”us”/”our”]. If you have questions about this Notice, please contact Customer Service at (855) 305-5060 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free).

This Notice describes how we will use and disclose your health information. The terms of this Notice apply to all health information generated or received by Sanford Health Plan, whether recorded in our business records, your medical record, billing invoices, paper forms, or in other ways.

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

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

1. **Help manage the health care treatment you receive:** We can use your health information and share it with professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional services.

2. **Pay for your health services:** We can use and disclose your health information as we pay for your health services. For example, we share information about you with your Primary Care Provider and/or Practitioner to coordinate payment for those services.

3. **For our health care operations:** We may use and share your health information for our day-to-day operations, to improve our services, and contact you when necessary. For example, we use health information about you to develop better services for you. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.

4. **Administer your plan:** We may disclose your health information to your health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

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

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

- **When required by law:** We will share information about you if federal laws require it, including with the Department of Health and Human services if it wants to see that we’re complying with federal privacy law.
- **For public health and safety:** We can share information in certain situations to help prevent disease, assist with product recalls, report adverse reactions to medications, and to prevent or reduce a serious threat to anyone’s health or safety.
- **Organ and tissue donation:** We can share information about you with organ procurement organizations.
- **Medical examiner or funeral director:** We can share information with a coroner, medical examiner, or funeral director when an individual dies.
- **Workers’ compensation and other government requests:** We can share information to employers for Workers’ compensation claims. Information may also be shared with health oversight agencies when authorized by law, and other special government functions such as military, national security and presidential protective services.
- **Law enforcement:** We may share information for law enforcement purposes. This includes sharing information to help locate a suspect, fugitive, missing person or witness.
- **Lawsuits and legal actions:** We may share information about you in response to a court or administrative order, or in response to a subpoena.
- **Research:** We can use or share your information for certain research projects that have been evaluated and approved through a process that considers an individual’s need for privacy.
We may contact you in the following situations:

- **Treatment options:** To provide information about treatment alternatives or other health related benefits or Sanford Health Plan services that may be of interest to you.
- **Fundraising:** We may contact you about fundraising activities, but you can tell us not to contact you again.

**YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION**

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

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

**Contact Information:**
Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110
(855) 305-5060 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free)

**OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION**

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

**CHANGES TO THIS NOTICE**

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

**EFFECTIVE DATE**

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

**NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT FOR SANFORD HEALTH PLAN**

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

How to Contact Sanford Health Plan [the “Plan”]

A thorough understanding of your coverage will enable you to use your benefits wisely. If you have any questions, please contact Sanford Health Plan using the information below.

<table>
<thead>
<tr>
<th>Physical Address</th>
<th>Mailing Address</th>
</tr>
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<tbody>
<tr>
<td>Sanford Health Plan</td>
<td>Sanford Health Plan</td>
</tr>
<tr>
<td>300 Cherapa Place, Suite 201</td>
<td>PO Box 91110</td>
</tr>
<tr>
<td>Sioux Falls, SD 57103</td>
<td>Sioux Falls, SD 57109-1110</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Customer Service</th>
<th>Free Translation Services</th>
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<tbody>
<tr>
<td>(855) 305-5060 (toll-free) or</td>
<td>(800) 892-0675 (toll-free)</td>
</tr>
<tr>
<td>TTY/TDD: (877) 652-1844 (toll-free)</td>
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<table>
<thead>
<tr>
<th>Sanford Health Plan In-Network Provider Locator</th>
<th>Prior Authorization (Certification)</th>
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<tbody>
<tr>
<td>If you need to locate a Provider in your area, call:</td>
<td>The Facility, your Provider, or you should call:</td>
</tr>
<tr>
<td>(855) 305-5060 (toll-free)</td>
<td>(855) 276-7214 (toll-free) or</td>
</tr>
<tr>
<td>TTY/TDD: (877) 652-1844 (toll-free)</td>
<td>TTY/TDD: (877) 652-1844 (toll-free)</td>
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<tr>
<th>Care/Case Management</th>
<th>Pharmacy Management</th>
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<tr>
<td>(888) 315-0884 (toll-free) or</td>
<td>(855) 263-3547 (toll-free)</td>
</tr>
<tr>
<td>TTY/TDD: (877) 652-1844 (toll-free)</td>
<td>TTY/TDD: (877) 652-1844 (toll-free)</td>
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<tr>
<th>Transportation</th>
<th>Website</th>
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<tr>
<td>(800) 236-4907 (toll-free) or</td>
<td><a href="http://www.sanfordhealthplan.com">www.sanfordhealthplan.com</a></td>
</tr>
<tr>
<td>TTY/TDD: (877) 652-1844 (toll-free)</td>
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<tr>
<th>mySanfordHealthPlan Member Portal</th>
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</thead>
<tbody>
<tr>
<td><a href="http://www.sanfordhealthplan.com/memberlogin">www.sanfordhealthplan.com/memberlogin</a></td>
<td></td>
</tr>
</tbody>
</table>

Member Rights

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

1. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; national origin; gender; age; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; or sources of payment for care, in accordance with access and quality standards.
2. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity and personal privacy.
3. Members have the right to request and receive a copy of medical records in the possession of the Plan and to request that they be amended or corrected.
4. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
5. Members have the right, but are not required to, select a Primary Care Practitioner (PCP) of their choice. If a Member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
6. Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable North Dakota and federal laws.
7. Members have the right to know the identity and professional status of individuals providing service to them and to know which Physician or other Provider is primarily responsible for their individual care. Members also have the right to receive information about the Plan’s clinical guidelines and protocols.
8. Members have the right to receive information on diagnosis (to the degree known), available treatment options and alternatives, presented in a manner appropriate to the Member’s condition and ability to understand, regardless of Member cost or coverage benefit for available treatment options. Members also have the right to participate in treatment decisions regarding their health care, including the right to refuse treatment.
9. Members have the right to give informed consent before the start of any procedure or treatment.
10. When Members do not speak or understand the predominant language of the community, the Plan will make reasonable efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
11. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and easy to read.
12. Members have the right to a clear grievance and Appeal process for complaints and comments and to have their issues resolved in a
timely manner.

13. Members have the right to Appeal any decision regarding medical necessity made by the Plan and its Providers.
14. Members have the right to make recommendations regarding the organization’s Member’s rights and responsibilities policies.
15. Members have the right to receive information about the organization, its services and Providers and Members’ rights and responsibilities, in accordance with 42 CFR §438.10.
16. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
17. Members have the right to be free to exercise all rights and that by exercising those rights; they shall not be adversely treated by the State, the Plan, and/or its participating Providers.

### Member Responsibilities

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

1. Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, Hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible Provider. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
2. Members are responsible for carrying their Plan ID cards with them and for having Member identification numbers available when contacting the Plan.
3. Members are responsible for following all access and availability procedures.
4. Members are responsible for seeking Emergency care at a Plan participating Emergency Facility whenever possible. In the event an ambulance is used, direct the ambulance to the nearest participating Emergency Facility unless the condition is so severe that you must use the nearest Emergency Facility. State law requires that the ambulance transport you to the Hospital of your choice unless that transport puts you at serious risk.
5. Members are responsible for notifying the Plan of an Emergency admission as soon as reasonably possible and no later than ten (10) days after becoming physically or mentally able to give notice.
6. Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible Provider or the Hospital.
7. Members are responsible for following their treatment plan as recommended by the Provider primarily responsible for their care. Members are also responsible for participating in treatment and understanding, to the degree possible, their health care needs. This includes developing mutually agreed-upon treatment goals and understanding any needs for managing chronic conditions, including mental health and substance use disorders.
8. Members are responsible for their actions if they refuse treatment or do not follow the Provider’s instructions.
9. Members are responsible for notifying the North Dakota Department of Human Services Division of Medical Services within ten (10) days at toll-free at (844) 854-4825 | ND Relay TTY: (800) 366-6888 (toll-free) if they change their name, address, or telephone number.
10. Members are responsible for notifying the North Dakota Department of Human Services Division of Medical Services of any changes of eligibility that may affect their membership or access to services.

### Fraud

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

**An act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, made by any applicant for health insurance coverage may be used to void their application, or this Certificate of Coverage, and cause the denial of claims.**

As a Member, you must:

1. File accurate claims. If someone else files claims on your behalf, you should review the form before you sign it;
2. Review any Explanation of Benefits (EOB) when you get them. Make certain that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered;
3. Never allow another person to seek medical treatment under your identity. If your ID card is lost, you should report the loss to Sanford Health Plan immediately; and
4. Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge. If you are concerned about any of the charges that appear on a bill, Explanation of Benefits (EOB), form, or other statement; or if you know of or suspect any illegal activity, call Sanford Health Plan toll-free at (855) 305-5060 | TTY/TDD: (877) 652-1844 (toll-free). All calls are strictly confidential.

### Coordinated Services Program (CSP)

Members utilizing health care or pharmacy services at a frequency or amount that is not medically necessary, and that exceeds generally accepted medical standards, will be placed in a CSP after review by, and upon, the recommendation of a Health Plan medical professionals and consultation with the North Dakota Department of Human Services Medical Services Division. Examples of actions that may cause you to be placed into the CSP include seeking duplicative, excessive, contraindicated, or conflicting health care services, including prescription drugs, from multiple Providers, and/or the abuse, misuse, or fraudulent actions relating to benefits or Plan services.
The following criteria will be used to determine if the CSP is appropriate:

a. Seriousness of incorrect, improper or excessive utilization of services;

b. Historical utilization of the Member; and

c. Availability of a coordinated services physician or pharmacy.

When a Member is placed in the CSP, the Plan will provide written notice to the Member, which will include:

1. The reason why the Member is being placed on the CSP;
2. The Member’s right to file an Appeal (See Section 7, Problem Resolution, for information on Appeals); and
3. The timeframe in which the Member has to file an Appeal.

Once a Member has exhausted the Plan’s internal Appeals process, the Member has a right to a State fair hearing and the Plan will inform the Member of the timeframe in which to file a request for such a hearing. The CSP administered by the Plan is in compliance with the lock-in requirements set forth in 42 CFR §431.54.

**Authorized Certificate of Coverage Changes**

No agent, employee, or representative of the Plan is authorized to vary, add to, change, modify, waive, or alter any of the provisions of this Certificate of Coverage. This Certificate of Coverage cannot be changed except by:

- Written amendment signed by one of our authorized officers
- Written amendment in which we exercise a right specifically reserved under this Certificate of Coverage that is signed by one of our authorized officers and mailed to you.

**Governing Law**

To the extent not superseded by the laws of the United States, this Certificate of Coverage will be construed in accordance with and governed by the laws of the state of North Dakota. Any action brought because of a claim under this Certificate of Coverage will be litigated in the state or federal courts located in the state of North Dakota and in no other.

**Incontestability**

Only an act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, made by any applicant or Member for health insurance coverage may be used to void or terminate this application or Certificate of Coverage and deny claims.

**Physical Examination**

We may have, at our own expense, a physician examine you when and as often as we may reasonably require during the pendency of a claim under this Certificate of Coverage.

**Legal Action**

You or your designated representative may not start legal action regarding a claim that we have denied under this Certificate of Coverage unless you have exhausted the Appeal process described in Section 7: Problem Resolution.

No legal or equitable action may be brought for payment of benefits under this Plan prior to the expiration of sixty (60) days following the Plan’s receipt of a claim for benefits or later than three (3) years after written proof of loss is required to be furnished.

**Disclosure Statement**

You hereby expressly acknowledge your notice that this Certificate of Coverage is a contract solely between you, the Plan Member, and us, Sanford Health Plan. You, the certificate holder, further acknowledge, and agree, that you have enrolled in this Plan based upon representations to the State of North Dakota, our authorized representatives, or us.

No other person, entity, or organization other than us is accountable or liable to you for any obligations created under this Certificate of Coverage. This paragraph does not create any additional obligations whatsoever on our part other than those obligations created under the provisions of this Certificate of Coverage.

**Nondiscrimination Policy**

Discrimination means treating someone differently because of a particular characteristic such as race, color, sex, age, disability, or religion. Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate against any potential or current Member on the basis of race; ethnicity; color; national origin; disability; sex; gender; sexual orientation; gender identity; religion; religious beliefs; medical condition, including current or past history of a mental health and substance use disorder; sources of payment for care; or age, in admission, treatment, or participation in its programs, services, and activities.

**Notice of Nondiscrimination**

In compliance with state and federal law, Sanford Health Plan shall not discriminate on the basis of age, gender, sex, color, race, national origin, disability, marital status, sexual preference, religious affiliation, public assistance status, a person’s status as a victim of domestic violence, or whether an advance directive has been executed. Sanford Health Plan shall not, with respect to any person and based upon any health factor or the results of genetic screening or testing (a) refuse to issue or renew a Certificate of Coverage, (b) terminate coverage, (c) limit benefits, or (d) charge a different Service Charge.
Sanford Health Plan:

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

If you need these services, tell us. 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 (complaint) with the Plan’s Compliance Officer, who serves as the Nondiscrimination Coordinator.

Call (855) 305-5060 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free) or write PO Box 91110, Sioux Falls, SD 57109-1110. You can file a grievance in person or by mail or phone. You may also submit information via your mySanfordHealthPlan secure member portal at www.sanfordhealthplan.com/memberlogin.

If you need help filing a grievance, we will help you.

To speak with someone for free in a language other than English, call (800) 892-0675.

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 ocrportal.hhs.gov/ocr/portal/lobby.jsf; or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

Complaint forms are available at www.hhs.gov/ocr/office/file/index.html.

**Special Communication & Language Access Services**

The Plan provides free interpreter services to assist Members who speak a language other than English. Once an interpreter is contacted, a three-way conversation will take place between the Member, Plan representative and the interpreter. All communication services provided through interpreters are confidential and free of charge to the Member.

The plan also provides free help for Members who are hearing or vision-impaired. Special communication services are provided at no cost to Members.

- Hearing-impaired Members wishing to contact the Plan may call toll-free at TTY/TDD: (877) 652-1844. This number will connect Members to all staff/departments within the Plan (For example, Customer Service, Utilization Management, or Case Management).
- Visually impaired Members may contact our Customer Service Department toll-free at (855) 305-5060 | TTY/TDD: (877) 652-1844 (toll-free) to request large-print or audio versions of the Plan’s documents and Member materials.
- For Members who have trouble reading Plan documents, or understanding written Member materials, Plan representatives can read information to Members over the phone.

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

The North Dakota Department of Human Services Division of Medical Services can also help with special communication needs. Members may reach North Dakota Medical Services toll-free at (844) 854-4825 | ND Relay TTY: (800) 366-6888.

**Medical Terminology**

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

**Definitions**

Capitalized terms are defined in Section 10 of this Certificate of Coverage.

**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.

**Conformity with State and Federal Laws**

Any provision in this Certificate of Coverage not in conformity with North Dakota Century Code chapters 26.1-18.1 and 26.1-36, North Dakota Administrative Code chapter 45-06-07, or any other applicable law or rule in this state, or at the federal level, may not be rendered invalid; but instead must be construed and applied as if it were in full compliance with any applicable North Dakota and Federal law and/or rule.
Service Area

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

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

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

<table>
<thead>
<tr>
<th>Clay</th>
<th>Emmet</th>
<th>Lyon</th>
<th>Osceola</th>
<th>Plymouth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dickinson</td>
<td>Ida</td>
<td>O’Brien</td>
<td>Sioux</td>
<td>Woodbury</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Becker</th>
<th>Clay</th>
<th>Jackson</th>
<th>Mahnomen</th>
<th>Nicollet</th>
<th>Polk</th>
<th>Roseau</th>
<th>Wilkin</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beltrami</td>
<td>Clearwater</td>
<td>Kandiyohi</td>
<td>Marshall</td>
<td>Nobles</td>
<td>Pope</td>
<td>Sibley</td>
<td>Watonwan</td>
</tr>
<tr>
<td>Big Stone</td>
<td>Cottonwood</td>
<td>Lac Qui Parle</td>
<td>Martin</td>
<td>Norman</td>
<td>Red Lake</td>
<td>Stearns</td>
<td>Yellow Medicine</td>
</tr>
<tr>
<td>Blue Earth</td>
<td>Douglas</td>
<td>Lake of the Woods</td>
<td>McLeod</td>
<td>Ottertail</td>
<td>Redwood</td>
<td>Stevens</td>
<td></td>
</tr>
<tr>
<td>Brown</td>
<td>Grant</td>
<td>Lincoln</td>
<td>Meeker</td>
<td>Pennington</td>
<td>Renville</td>
<td>Swift</td>
<td></td>
</tr>
<tr>
<td>Chippewa</td>
<td>Hubbard</td>
<td>Lyon</td>
<td>Murray</td>
<td>Pipestone</td>
<td>Rock</td>
<td>Traverse</td>
<td></td>
</tr>
</tbody>
</table>
Section 1. Enrollment

How and When Coverage Begins

IMPORTANT INFORMATION: The terms of your coverage are defined in the documents that make up your contract. Your contract includes this Certificate of Coverage and any amendments. A Member’s enrollment in the Plan, and coverage under this Certificate, will become effective on the date determined by the North Dakota Department of Human Services Division of Medical Services and Sanford Health Plan in accordance with the Medicaid Agreement.

NOTE: The North Dakota Department of Human Services Division of Medical Services will notify a Member of the effective date of coverage. Sanford Health Plan will mail the Member an identification (ID) card and enrollment packet with plan materials.

DEPENDENTS

This Certificate of Coverage does not cover dependents. A North Dakota Medicaid Expansion Member should contact the North Dakota Department of Human Services Division of Medical Services to discuss other coverage options at (701) 328-2321 or toll-free at (844) 854-4825 | ND Relay TTY: (800) 366-6888. If an individual does not qualify for North Dakota Medicaid or North Dakota Medicaid Expansion, the individual can explore whether he or she may qualify for federal health insurance Marketplace coverage at www.healthcare.gov. The federal government’s Health Insurance Marketplace Call Center may be reached toll-free at (800) 318-2596 | TTY/TDD: (855) 889-4325 (toll-free).

Eligibility Requirements

To be eligible to enroll in this plan, you:
1. Must be eligible for the North Dakota Medicaid Expansion Program, as determined by the North Dakota Department of Human Services Division of Medical Services; and
2. Must legally reside in the state of North Dakota, as determined by the North Dakota Department of Human Services Division of Medical Services.
3. Not be enrolled in or covered by Medicare, this State’s Traditional Medicaid program, or any other state’s Medicaid program.

Newborn and Dependent Exclusion. This Certificate of Coverage does not cover newborns and/or Dependents. A newborn infant may be eligible to be covered by the North Dakota Medicaid or the Children’s Health Insurance Program from birth. Contact your local county social service office or the North Dakota Department of Human Services Division of Medical Services for questions regarding eligibility.

Medicare Exclusion. This Certificate of Coverage does not cover any individual who is eligible for or enrolled in Medicare. To be eligible for coverage, a Member cannot also have coverage under any Medicare program. If it is determined that a Member also had coverage under Medicare at the time of eligibility under Medicaid Expansion, coverage under Medicaid Expansion shall cease and may be retroactively terminated to the date Medicare eligibility occurred, as determined by the North Dakota Department of Human Services Division of Medical Services.

Effective Date of Eligibility. If a Member is determined eligible during a month, he or she is eligible for the entire month. In some cases, Members may be retroactively determined eligible. Once a Member (age 19-64) is determined to be Medicaid Expansion eligible, eligibility will occur on the date determined by the North Dakota Department of Human Services Division of Medical Services. The Plan is not responsible for paying for health care services prior to the date of eligibility determination. If a Member is disenrolled from the Plan, and is in an inpatient hospital setting on the date of disenrollment, the Plan will be responsible for all charges incurred until the date of discharge.

Final Determination. In all cases, the North Dakota Department of Human Services Division of Medical Services shall make the final determination of an individual’s eligibility to enroll and continue enrollment in the Plan. The North Dakota Department of Human Services Division of Medical Services shall also make all determinations related to Member eligibility for cost sharing.

Coverage Changes

The following events may require a change in your coverage, as determined by the North Dakota Department of Human Services Division of Medical Services:
1. Active Duty in the military;
2. Eligibility or enrollment in Medicare;
3. Enrollment in this State’s or any other state’s Traditional Medicaid program;
4. Death;
5. Pregnancy;
6. Change in the number of people living in your household;
7. Incarceration or release from incarceration;
8. Change in citizenship status or Native Alaskan/Native American Tribal affiliation;
9. A change in employment status or income; and
10. A change in legal residency or a move outside of the state of North Dakota, as determined by the North Dakota Department of Human Services.
Within ten (10) days of the date of an event that may change your eligibility for coverage: You must tell your local county social service office or the North Dakota Department of Human Services Medical Service Division by calling (701) 328-2321 | (844) 854-4825 (toll-free) | TTY/TDD: (800) 366-6888 (toll-free).

NOTE: In order to ensure timely delivery of any notification from the Department of Human Services Medical Services Division, and to prevent possible disenrollment due to failure to respond, report any address changes to your local county social service office as soon as you know you will be moving, or have a change in mail delivery.
### Section 2. How Coverage Ends

#### Termination of Coverage

**Termination of Certificate by Sanford Health Plan or the North Dakota Department of Human Services Division of Medical Services.** This Certificate will automatically terminate upon the effective date of termination of the Medicaid Agreement. Enrollment and coverage of all Members will terminate at 11:59 p.m. on the date of the termination of this Certificate, except as otherwise provided by the Medicaid Agreement.

**Termination of Member Enrollment and Coverage will be determined by the North Dakota Department of Human Services Division of Medical Services.** A Member’s enrollment and coverage under this Certificate will terminate at the date and time determined by the North Dakota Department of Human Services Division of Medical Services when any of the following occurs:

a. The Member ceases to be a legal resident of North Dakota or moves outside of the state of North Dakota as determined by the North Dakota Department of Human Services Division of Medical Services.

b. The Member ceases to be eligible for the Medicaid Expansion Program as determined by the North Dakota Department of Human Services Division of Medical Services.

c. The Member dies.

Sanford Health Plan will not initiate a Member’s disenrollment and termination of coverage unless such a request is at the direction of the North Dakota Department of Human Services Division of Medical Services.

**Disenrollment.** Termination of coverage may be requested by the Plan for any of the following reasons:

a. The Member makes material misrepresentations or commits fraud; or

b. The Member misuses or commits fraud in the use of his or her Plan ID card; or

c. The Member’s conduct is abusive or obstructive to Sanford Health Plan’s personnel, Participating Providers or other Members; or

d. The Member repeatedly and intentionally misuses Sanford Health Plan’s benefits and services; or

e. The Member fails to cooperate in coordinating benefits or subrogating the Member’s right of recovery; or

f. Death of a Member; or

g. Confinement of a Member in an institution when such confinement is a non-covered service under this Certificate of Coverage.

A determination by the North Dakota Department of Human Services Division of Medical Services will be made within thirty (30) calendar days of receiving the request for Member disenrollment from the Plan. If the Plan’s disenrollment request is approved, the Member will be notified of the proposed disenrollment in writing, and have 30 calendar days from the date of the written notice to Appeal the State’s determination by requesting a State Fair Hearing. See Section 7, Problem Resolution, for State Fair Hearing rights.

Sanford Health Plan will not terminate a Member’s enrollment and coverage because of an adverse change in the Member’s health status, uncooperative or disruptive behavior resulting from his or her special needs, or because of the Member’s utilization of medical services, diminished mental capacity, or the fact that the Member has exercised rights under the Member Complaint, Grievance and Appeal procedures.

**Disenrollment by the Member.** A Member may disenroll from North Dakota Medicaid Expansion, as delivered by Sanford Health Plan, with or without cause. A Member who wishes to disenroll from North Dakota Medicaid Expansion should contact the North Dakota Department of Human Services Division of Medical Services and follow the disenrollment procedures required by the Department.

A Member’s coverage under this Certificate ceases automatically on the effective date of the Member’s disenrollment. The effective date of disenrollment will be determined by the North Dakota Department of Human Services Division of Medical Services.

**Decisions to Terminate, Suspend, or Reduce Previously Authorized Covered Services.** If the Plan terminates, suspends, or reduces previously authorized covered services, the Plan shall notify the Member, the Member’s Authorized Representative, and/or Practitioners and Providers involved in the provision of the service as expeditiously as the Member’s health requires and within the following timeframes:

a. At least ten (10) calendar days prior to the date of termination, suspension, or reduction in covered services; or

b. If the Plan has facts indicating that the action should be taken because of probable fraud by the Member and the facts have been verified, if possible, through secondary sources, five (5) calendar days before date of the termination, suspension, or reduction in covered services; or

c. By the date of the termination, suspension, or reduction in covered services if:

   1. the Plan has factual information confirming the death of the Member;

   2. the Plan receives a clear, written statement from the Member that:

      i. The Member no longer wants the services; or

      ii. The Member gives information that requires termination or reduction of services and indicates that he or she understands that this shall be the result of supplying that information;

   3. The Member has been admitted to an institution where he or she is ineligible for further services;

   4. The Member’s whereabouts are unknown and the post office returns mail directed to the Member indicating no forwarding address. In this case, any discontinued services shall be reinstated if the Member’s whereabouts become known during the time the Member remains eligible for services;

   5. The Member has been accepted for Medicaid services by another local jurisdiction; or

   6. The Member’s physician prescribes the change in the level of medical care.
The above actions are subject to review and approval by the North Dakota Department of Human Services Division of Medical Services.

Questions about the disenrollment process should be directed to:
Your local county social service office or the North Dakota Department of Human Services Medical Service Division at 600 East Boulevard Ave, Dept 325, Bismarck, ND 58505-0250 | Call (701) 328-2321 | Toll-free (844) 854-4825 | ND Relay TTY: (800) 366-6888 | E-mail dhsmed@nd.gov.

Retroactive Eligibility and Terminations
Sanford Health Plan may be notified by the state of North Dakota that a Member has lost eligibility retroactively. This occurs sometimes, and when it does, Sanford Health Plan takes back any payments made to Providers for dates when the Member did not have coverage with Medicaid Expansion. If you have questions on your eligibility, please contact your local county office.
Section 3. How You Get Care

Identification cards

The Plan will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Provider, a health care facility, or fill a prescription at a Plan pharmacy. If you fail to show your ID card at the time you receive health care services or prescription drugs, you may be responsible for payment of the claim after the Participating Practitioner/Provider’s timely filing period of three hundred and sixty-five (365) days has expired. Your coverage will be terminated by the North Dakota Department of Human Services Division of Medical Services if you use your ID card fraudulently or allow another individual to use your ID card to obtain services.

If you need replacement cards, call us toll-free at (855) 305-5060 | TTY/TDD: (877) 652-1844 (toll-free) or write to us at PO Box 91110 Sioux Falls, SD 57109-1110. You may also request replacement cards through our website at www.sanfordhealthplan.com.

Conditions for Coverage

Members shall be entitled to coverage for the Health Care Services (listed in the “Covered Services,” in Section 4) that are:

1. Medically Necessary and/or Preventive
2. Received from or provided under the orders or direction of a Participating Provider
3. Approved by the Plan, including pre-approval (Certification) where required
4. Within the scope of health care benefits covered by the Plan.

However, this specific condition does not apply to Emergency Conditions or Urgent Care Situations in and out of the Plan’s Service Area. In such cases, the services will be covered even if they are provided by a Non-Participating Provider.

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

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

In addition, all Health Care Services are subject to:

1. The exclusions and limitations described in Sections 4 and 5; and
2. Any applicable cost-sharing amount(s), as stated in the Summary of Benefits and Coverage.

In-Network Coverage

In-Network Coverage means Covered Services that are received:

1. from a Sanford Health Plan Participating Practitioner/Provider within the Sanford Health Plan Service Area; or
2. from a Participating Practitioner/Provider outside of the Sanford Health Plan Service Area if a Participating Provider and/or Provider has recommended the referral; and
   a. the Plan has authorized the referral to a Participating Practitioner/Provider outside of the Plan’s Service Area; or
   b. the Plan has authorized the referral from a Participating Practitioner/Provider to a Non-Participating Provider; or
3. in a situation where a Member has an Emergency Medical Condition, or when an Urgent Care Situation exists; or
4. when the Member does not have appropriate access to a Participating Practitioner and/or Provider.

NOTE: For details on coverage Out-of-Network and Out-of-State, please see Section 4(h).

Coverage is not provided for elective health care services if you travel out of the Plan’s Service Area for the purpose of seeking medical treatment outside the Plan’s Service Area (as defined in this Certificate of Coverage).

Additionally, if you choose to go to a Non-Participating Provider when access to a Participating Practitioner/Provider is available, you will be responsible for all financial charges from that Provider. **There is no coverage for services received outside of the United States.**

Appropriate Access

Primary Care Physicians, Specialty Providers and Hospital Providers

1. Appropriate access for Primary Care Practitioners, Specialty Providers, and Hospital Provider sites is defined as the Plan ensuring that Participating Providers are available within fifty (50) miles of a Member’s legal North Dakota residence.
2. Appropriate access includes access to Participating Providers when the Member has traveled outside of the Service Area and has either obtained prior approval by the Plan, or is experiencing an Emergency Medical Condition or Urgent Care Situation.
3. Members who are inside the Plan’s Service Area must use the Plan’s contracted Network of Participating Providers. If you are traveling within the Service Area where Participating Providers are available then you must use Participating Providers.
4. If a Member chooses to go to a Non-Participating Provider when access is available in-network, the Member will be responsible for all financial charges from that Provider.
5. All services must be rendered within the United States.
Transplant Services
Transplant Services must be performed at designated Plan Participating Centers of Excellence, or Plan-approved facilities, and is not subject to Appropriate Access standards, as outlined above. Transplant coverage includes related post-surgical treatment, drugs, eligible travel, and living expenses and shall be subject to and in accordance with the provisions, limitations, and terms of the Plan’s transplant policy.

<table>
<thead>
<tr>
<th>Coverage Determination Review Process</th>
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</thead>
<tbody>
<tr>
<td>Coverage Determinations - OVERVIEW</td>
</tr>
<tr>
<td>The Customer Service department will coordinate the Covered Service Determination, Non-Covered Service Determination, and Appeal process. Customer Service will review the request using standards established by the Plan and, if the request is approved, provide notification of the determination, or if the request is denied, provide notification of the determination and relevant Appeal rights. A coverage determination will be made within fourteen (14) calendar days of receipt of the request. If the Plan is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fourteen (14) calendar days. Within fourteen (14) calendar days of receiving a service request, Sanford Health Plan will notify the Member or Member’s Authorized Representative if an extension is needed and the date by which it expects to make a decision. The Plan will issue and carry out its determination as expeditiously as the Member’s medical condition requires and no later than the date on which the extension expires. For coverage determinations, Customer Service reviews Certificate of Coverage language, contractual terms, and administrative policies related to services covered under this Plan, and requests for coverage of services that do not involve medical necessity. All coverage determinations that are Adverse will be made by the person assigned to coordinate Benefit, Denial, and Appeal processes. Customer Service is available between the business hours of 8 a.m. and 5 p.m. Central Time, Monday through Friday, by calling Sanford Health Plan’s toll-free number (855) 305-5060</td>
</tr>
</tbody>
</table>

Prospective (Standard/Non-Urgent) Review Process for Coverage Determinations

A person assigned to coordinate the Benefit, Denial and Appeal process will review the request against the Certificate of Coverage and Plan policies. A covered service determination will be made within fourteen (14) calendar days of receipt of the request. If Sanford Health Plan is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fourteen (14) calendar days. Within fourteen (14) calendar days of the request for a coverage determination, Sanford Health Plan will notify the Member, or Member’s Authorized Representative, of the need for an extension and the date by which it expects to make a decision.

Lack of Necessary Information
If Sanford Health Plan is unable to make a decision due to lack of necessary information, it will notify the Member or the Member’s Authorized Representative of what specific information is necessary to make the decision within fourteen (14) calendar days of the Prospective (Pre-service) Review request. Sanford Health Plan will give the Member a reasonable amount of time taking into account the circumstances, but not less than forty-five (45) calendar days to provide the specified information.

In addition to notifying the Member, Sanford Health Plan will notify the Practitioner/Provider of the information needed if the request for health care services came from the Practitioner/Provider. Sanford Health Plan shall have the remainder of the fourteen (14) calendar days from receipt of the request for authorization to consider the request, measured from the earlier of the date on which Sanford Health Plan receives additional information from the Member or Practitioner/Provider or forty-five (45) calendar days after the notification to the Member.

Timeframe Extensions
If Sanford Health Plan is unable to make a coverage determination due to matters beyond its control, it may extend the decision timeframe once, for up to fourteen (14) calendar days. Sanford Health Plan will give written or electronic notification of the determination to certify or deny the service within fourteen (14) calendar days of the request (or in the case of an extension, by the end of the timeframe given to provide information) to the Member.

Non-Covered Service Determinations
If Sanford Health Plan’s decision is a Non-Covered Service Determination, Sanford Health Plan shall provide written notice in accordance with the Written Notification Process for Covered Service and Adverse Benefit Determinations below. At this point, the Member can appeal the Non-Covered Service Determination. Refer to “Problem Resolution” in Section 7 for details.

Retrospective (Standard/Non-Urgent) Review Process for Coverage Determinations

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

Sanford Health Plan will review the request and make the decision to approve or deny within thirty (30) calendar days of receipt of the request. Written or electronic notification will be made to the Member within those thirty (30) calendar days. Members will be notified by the Plan upon receipt of the Appeal and upon the Plan’s decision on the Appeal.

If Sanford Health Plan is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to
fourteen (14) calendar days. Within thirty (30) calendar days of the request for review, Sanford Health Plan will notify the Member or Member’s Authorized Representative of the need for an extension and the date by which it expects to make a decision.

<table>
<thead>
<tr>
<th>Utilization Review Process</th>
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<tbody>
<tr>
<td>The Plan’s Utilization Management Department is available between the business hours of 8:00 am to 5:00 pm Central Time, Monday through Friday, by calling the Plan’s toll-free number (855) 276-7214</td>
</tr>
<tr>
<td>The date of receipt for non-Urgent Requests received outside of normal business hours will be the next business day. The date of receipt for Urgent Requests will be the actual date of receipt, whether or not it is during normal business hours.</td>
</tr>
<tr>
<td>All Utilization Management Adverse Benefit Determinations will be made by the Sanford Health Plan Chief Medical Officer, designee, or appropriate Practitioner.</td>
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</tbody>
</table>

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<thead>
<tr>
<th>Prospective (pre-service) Review of Services (Certification/Prior Authorization)</th>
</tr>
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<tbody>
<tr>
<td>The Member is ultimately responsible for obtaining prior authorization from the Utilization Management Department in order to receive In-Network coverage. However, information obtained by the provider/practitioner’s office may also satisfy this requirement. Primary care physicians and any Participating Specialists have been given instructions on how to get the necessary authorizations for surgical procedures or hospitalizations you may need.</td>
</tr>
<tr>
<td>Members are responsible to confirm with the Practitioner/Provider that any required Pre-Authorization (Certification) has been obtained from the Plan.</td>
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</tbody>
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<thead>
<tr>
<th>Prior Authorization</th>
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<tbody>
<tr>
<td>Prior authorization (certification) is approval of a requested service for medical care, including care for behavioral, mental health, and/or substance use disorders, prior to receiving the service. Prior authorization (or precertification/pre-service decisions) is designed to facilitate early identification of the treatment plan to ensure medical management and available resources are provided throughout an episode of care. The Plan determines approval for prior authorization based on appropriateness of care and service and existence of coverage. The Plan does not compensate Practitioners/Providers or other individuals conducting utilization review for issuing denials of coverage or service care. Any financial incentives offered to Utilization Management decision makers do not encourage decisions that result in underutilization and do not encourage denials of coverage or service.</td>
</tr>
<tr>
<td>Prior authorization is required for all inpatient admissions of Plan Members. This requirement applies to, but is not limited to the following:</td>
</tr>
<tr>
<td>a. Acute care hospitalizations, including medical, surgical, obstetric and non-Emergency mental health or substance use disorder inpatient admissions;</td>
</tr>
<tr>
<td>b. Residential Treatment Facility admissions; and</td>
</tr>
<tr>
<td>c. Rehabilitation center admissions.</td>
</tr>
<tr>
<td>Admission before the day of non-Emergency surgery will not be authorized unless the early admission is medically necessary and specifically approved by the Plan. Coverage for Hospital expenses prior to the day of surgery will be denied unless authorized prior to being incurred. See “Services that Require Prospective Review” on the following pages.</td>
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<table>
<thead>
<tr>
<th>Services that Require Prospective Review/Prior Authorization (Certification)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Admissions; See Sections 4(a), 4(b) and 4(d) for coverage details;</td>
</tr>
<tr>
<td>2. Ambulance Services. See Section 4(c) for coverage details;</td>
</tr>
<tr>
<td>3. Clinical Trials. See Section 4(a) for coverage details;</td>
</tr>
<tr>
<td>4. Home Health, Hospice and Home IV therapy services; See Sections 4(a) and 4(b) for coverage details;</td>
</tr>
<tr>
<td>5. Select Durable Medical Equipment (DME). See DME requiring Certification in Section 4(a);</td>
</tr>
<tr>
<td>6. Transplant services. See Section 4(b) for coverage details;</td>
</tr>
<tr>
<td>7. Implant/Stimulators. See Section 4(a) for coverage details;</td>
</tr>
<tr>
<td>8. Oncology Services and Treatment. See Sections 4(a) for coverage details;</td>
</tr>
<tr>
<td>9. Outpatient Services. See Sections 4(a), 4(b), 4(d) and 4(f) for coverage details;</td>
</tr>
<tr>
<td>10. Outpatient Surgery. See Sections 4(a), 4(b), 4(d) and 4(f) for coverage details;</td>
</tr>
<tr>
<td>11. Pharmacy services obtained in jurisdictions other than North Dakota and its three contiguous states (Minnesota, Montana, and South Dakota). See Section 4(e) for coverage details.</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Prescription Drugs that Require Prior Authorization and Exceptions to the Formulary Process</th>
</tr>
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<tbody>
<tr>
<td>To be covered by Sanford Health Plan, certain medications in the Sanford Plan Formulary [a list of drugs a health plan will pay for] require prior authorization. This can be in the form of written or verbal authorization.</td>
</tr>
<tr>
<td>To request prior authorization for a medication or an exception to the formulary verbally, please call the Pharmacy Management Department at (855) 263-3547</td>
</tr>
</tbody>
</table>

Sanford Health Plan 16

Section 3
Written requests for prior authorization or an exception to the formulary may be sent to the Plan via an online fillable form, available by logging into your account at www.sanfordhealthplan.com/memberlogin. You or your Practitioner/Provider may also fax a letter of Medical Necessity to Pharmacy Management at (605) 328-6813.

Requests for prior authorization will be responded to within twenty-four (24) hours.

In an emergency situation, the plan provides for the dispensing of at least 72-hour supply of a covered outpatient prescription drug in accordance with 42 CFR § 438.3(s)(6) and § 1927(d)(5) of the Social Security Act.

If a prescription drug or medication is authorized by the Plan and/or an exception to the formulary is granted, coverage of the non-formulary drug will be provided for the duration of the prescription, including refills.

The Plan will use appropriate practitioners to consider exception requests and promptly grant an exception to the drug formulary, including exceptions for anti-psychotic and other drugs to treat mental health conditions, for a Member when the practitioner prescribing the drug indicates to the Plan that:

- the formulary drug causes an adverse reaction in the patient;
- the formulary drug is contraindicated for the patient; or
- the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

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

For contraceptives not currently in the Plan Formulary, if the attending Provider determines that a drug/device is medically indicated and an exception to the formulary is granted, the contraceptive drug/device will be covered by the Plan at 100% (no charge). For more information on specific prescription drugs that may require prior authorization including oral medications, step therapy and injectable medications, refer to Section 4(e) and your Formulary.

**Standard Pharmaceutical Exception Requests**

A decision and notification will be made within 72 hours of receipt of the request for Standard Exception Requests, unless the request is of an urgent nature, in which case the decision and notification would be made as soon as possible, but no later than within 24 hours of receipt of the Expedited Exception Request.

**Expedited Pharmaceutical Exception Requests**

If a medication or drug exception request is of an urgent nature, a decision and notification will be made as soon as possible, but no later than within 24 hours of receipt of the Expedited Exception Request.

Standard requests for an exception to the formulary will be determined within seventy-two (72) hours; Expedited requests for an exception to the formulary will be determined within twenty-four (24) hours.

**Denials**

If the decision is to deny the request and the request is a Standard Exception Request, the Member and Provider will be given a reason for the denial, standard appeal rights will be given, and the Member, applicable Provider(s) and/or Practitioner(s), and if applicable, the Member’s Authorized Representative, will be notified by phone and in writing. At this point, the Member has the right to request an Appeal of Adverse Benefit Determination. Refer to see Section 7, Problem Resolution, for details on this process.

NOTE: In determining whether to grant an exception, the Plan adheres to 42 CFR §438.3(s)(6), with procedures, as outlined above, allowing Members to request and gain access to clinically appropriate drugs requiring prior authorization or not covered under the Plan’s Formulary.

**Prospective (Non-Urgent Pre-Service) Review Process for Elective Inpatient Hospitalizations, and Non-Urgent Medical Care Requests**

All requests for prior authorization (Certification) are to be made by the Member or Physician’s office at least three (3) business days prior to the scheduled admission or requested service, provided that the Plan’s Utilization Management Department may review a request for a period of up to fourteen (14) calendar days from the date of the request, together with the information supporting the request, have been received.

The Utilization Management Department will review the Member’s medical request against standard criteria.

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

- **a.** Member medical information including:
  - i. diagnosis
  - ii. medical history
  - iii. presence of complications and/or co-morbidities;
- **b.** Consultation with the treating Physician, as appropriate;
- **c.** Availability of resources and alternate modes of treatment; and
- **d.** For admissions to facilities other than acute Hospitals additional information may include but are not limited to the following:
  - i. history of present illness
  - ii. Member treatment plan and goals
  - iii. prognosis
  - iv. staff qualifications
  - v. twenty-four (24) hour availability of qualified medical staff.
You are ultimately responsible for obtaining authorization (Certification) from the Utilization Management Department. Failure to obtain Certification will result in the denial of payment on your claim. However, information provided by the Physician’s office to the Plan may also satisfy the requirement of a Member to get prior authorization (Certification). You are responsible to confirm with the Practitioner/Provider that any required Plan pre-authorization (Certification) has been obtained.

For Medical Necessity Requests: The Utilization Management Department will review the Member profile information against standard criteria. A determination for elective inpatient or non-Urgent Care Situations will be made by the Utilization Management Department within fourteen (14) calendar days of receipt of the request. If the Utilization Management Department is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fourteen (14) calendar days.

Within fourteen (14) calendar days of the request for authorization (Certification), Sanford Health Plan will notify the Member or Member’s Authorized Representative of the need for an extension and the date by which it expects to make a decision. Sanford Health Plan will also provide written notice of the reason for such an extension. The Plan will issue and carry out its determination as expeditiously as the Member’s medical condition requires and no later than the date on which the extension expires. You may file a complaint (grievance) if you disagree with the Plan’s extension of the time allowed for issuing the decision.

Lack of Necessary Information
If the Plan is unable to make a decision due to lack of necessary information, it will notify the Member or the Member’s Authorized Representative of what specific information is necessary to make the decision within fourteen (14) calendar days of the Prospective (preservice) Review request.

Sanford Health Plan will give the Member or the Member’s Authorized Representative reasonable amount of time taking into account the circumstances, but not less than forty-five (45) calendar days to provide the specified information. In addition to notifying the Member, the Plan will notify the Practitioner/Provider of the information needed if the request for health care services came from the Practitioner/Provider.

Timeframe Extensions
The Plan shall give the remainder of the fourteen (14) calendar days from receipt of the request for authorization to consider the request, measured from the earlier of the date on which the Plan receives additional information from the Member or Practitioner/Provider, or forty-five (45) calendar days after the notification to the Member or Practitioner/Provider.

The Prospective (pre-service) Review determination shall either be Certification of the requested service or additional review will be needed by the Plan Chief Medical Officer or designee, however, the decision will be made within fourteen (14) calendar days of that date.

NOTE: If the information is not received by the end of the forty-five (45) calendar day extension, Sanford Health Plan will deny the request.

If the Plan receives a request that fails to meet the procedures for Prospective (Pre-Service) Review Request, the Plan will notify the Practitioner/Provider or Member of the failure and proper procedures to be followed as soon as possible but no later than five (5) calendar days after the date of the failure. The Plan will give oral and/or written notification to the Member, Practitioner and those Providers involved in the provision of the service.

Sanford Health Plan will give written or electronic notification of the determination to certify or deny the service within fourteen (14) calendar days of the request (or in the case of an extension, of the end of the time frame given to provide information) to the Member, or the Member’s Authorized Representative, attending Practitioner/Provider and those Providers involved in the provision of the service. The Utilization Management Department will assign an authorization number for the approved service.

Adverse Benefit Determinations
If the Plan’s determination is an Adverse Benefit Determination, the Plan shall provide written notice in accordance with the Written Notification Process for Adverse Benefit Determinations procedure below. At this point, the Member can request an Appeal of the Adverse Benefit Determination. Refer to “Problem Resolution” in Section 7 for details.

### Prospective (Pre-Service) Review Process for Urgent/Emergency (Urgent Pre-service) Medical Care Requests

An **Emergency Medical Condition** is a medical condition of recent onset and severity, including severe pain, that would lead a Prudent Layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person’s health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.

An **Urgent Care Situation** is a degree of illness or injury, which is less severe than an Emergency Medical Condition, but requires prompt medical attention within twenty-four (24) hours, such as stitches for a cut finger. If an Urgent Care Situation occurs, Members should contact their Primary Care Provider immediately, if one has been selected, and follows his or her instructions. A Member may always go directly to a participating acute care or after-hours clinic.

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

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

In determining whether a request is “Urgent,” the Plan shall apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. When a Practitioner with knowledge of the Member’s medical condition determines the condition to be an **Urgent**
For Urgent Care (Pre-service) Requests: the determination for medical care, including care for behavioral, mental health, and/or substance use disorders will be made by the Utilization Management Department as soon as possible (taking into account medical exigencies, but no later than seventy-two (72) hours) after receipt of the request. Notification of the determination will be made to the Member or the Member’s Authorized Representative, Practitioner and those Providers involved in the provision of the service via oral communication by the Utilization Management Department as soon as possible but no later than seventy-two (72) hours of receipt of the request. For authorizations (Certifications) and Adverse Benefit Determinations, the Plan will give electronic or written notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service as soon as possible but no later than 72 hours of the oral notification.

Prospective (Pre-Service) Review (Urgent Care Request) is not required for Emergency Medical Conditions. However, the Plan must be notified by the Member as soon as reasonably possible but no later than ten (10) days after the Member is physically or mentally able to do so. A Member’s Authorized Representative may notify the Plan on the Member’s behalf with written permission of the Member.

Lack of Necessary Information
If the Plan is unable to make a decision due to lack of necessary information, it may extend the decision timeframe once for up to forty-eight (48) hours to request additional information. An extension is permitted if the Member, Member’s Authorized Representative, and/or Practitioner/Provider requests it or the Plan justifies to the State, upon request, that additional information is needed and that the extension is in the Member’s interest.

Timeframe Extensions
Within twenty-four (24) hours after receipt of the Urgent/Emergency (Urgent Pre-service) Medical Care and/or Pharmaceutical Request, the Plan will notify the Member, or the Member’s Authorized Representative, of what specific information is necessary to make the decision. In addition to notifying the Member, the Plan will notify the Practitioner of the information needed if the request for health care services came from the Practitioner. Sanford Health Plan will give the Member or the Member’s Authorized Representative a reasonable amount of time taking into account the circumstances, but not less than forty-eight (48) hours to provide the specified information.
If the Plan receives a request that fails to meet the procedures for Urgent Prospective (Pre-service) Review requests, the Plan will notify the Practitioner and Member of the failure and proper procedures to be followed as soon as possible but no later than twenty-four (24) hours after the date of the failure. The Plan will give oral and/or written notification to the Member, Practitioner and those Providers involved in the provision of the service.

The Member, or the Member’s Authorized Representative, Practitioner and those Providers involved in the provision of the service will be given oral notification of the Plan’s determination as soon as possible but no later than forty-eight (48) hours after the earlier of 1) the Plan’s receipt of the requested information; or 2) the end of the period provided to submit the requested information. The Plan will also give electronic or written notification of the decision as soon as possible but no later than within 72 hours of the oral notification. Failure to submit necessary information is grounds for denial of authorization (Certification). Extended authorization decisions will be made on the date on which the extended period expires.

Adverse Benefit Determinations
If the Plan’s determination is an Adverse Benefit Determination, the Plan shall provide written notice in accordance with the Written Notification Process for Adverse Benefit Determinations procedure below. At this point, the Member can request an Appeal of Adverse Benefit Determination. Refer to “Problem Resolution” in Section 7 for details.

Concurrent Review Process for Medical Care Requests

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

Additional stay days must meet the continued stay review criteria and, if acute levels of care criteria are not met, a decision to certify further treatment will be made at that time. Authorization (Certification) of inpatient health care stays will terminate on the date the Member is to be discharged from the Hospital or Facility (as ordered by the attending Practitioner). Hospital/Facility days accumulated beyond the ordered discharge date will not be certified unless the continued stay criteria continue to be met. Charges by Practitioners/Providers associated with these non-certified days are non-covered.

Requesting Authorized Services be Extended
A Member who is requesting an extension of an approved ongoing course of treatment beyond the ordered period of time or number of treatments must request authorization from the Plan at least twenty-four (24) hours in advance of the termination of such continuing services.

If the Utilization Management Department denies the extension of such treatment, it will advise the Member or the Member’s Authorized Representative and Practitioners/Providers within twenty-four (24) hours of receipt of the request. If the Member appeals this denial, the health care services or treatment that is the subject of the Adverse Benefit Determination shall be continued without cost to the Member while the determination undergoes Appeal procedures as described in Section 7 of this Certificate of Coverage.

If the internal review process results in a denial of the request for an extension, the payment of benefits for such treatment shall terminate but the Member may pursue the Appeal Rights described in Section 7. The health care service or treatment that is the subject of the Adverse Benefit Determination shall be continued without liability to the Member until the Member or the Member’s Authorized Representative has been notified of the determination by the Plan with respect to the internal review request made pursuant to the Plan’s Appeal Procedures.

Any reduction or termination by the Plan during the course of treatment before the end of the period or number treatments shall constitute an Adverse Benefit Determination.
Urgent Concurrent Reviews Requested At Least Twenty-Four (24) Hours in Advance of an Expiring Authorization
For requests to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the Plan shall conduct an Urgent Concurrent Review and orally notify the Member, or the Member’s Authorized Representative, Practitioner and those Providers involved in the provision of the service as soon as possible taking into account the Member’s medical condition but in no event more than twenty-four (24) hours after the date of the Plan’s receipt of the request. The Plan will provide electronic or written notification of an authorization (Certification) to the Member, the Member’s Authorized Representative, Practitioner and those Providers involved in the provision of the service within 72 hours after the oral notification.

Adverse Benefit Determinations
The Plan shall provide written or electronic notification of the Adverse Benefit Determination to the Member, or the Member’s Authorized Representative, and those Providers involved in the provision of the service sufficiently in advance (but no later than 72 hours of the telephone (oral) notification) of the reduction or termination to allow the Member or, the Member’s Authorized Representative to file an Appeal request of the Adverse Benefit Determination and obtain a determination with respect to that review before the benefit is reduced or terminated. The Plan will terminate payment of benefits on the date that oral notification of the reduction or termination of benefits is made.

Urgent Concurrent Reviews Requested Within Twenty-Four (24) Hours of an Expiring Authorization
If the request to extend Urgent Concurrent Review is not made at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments for medical care, including care for behavioral, mental health, and/or substance use disorders, Sanford Health Plan will treat it as an Urgent Prospective (pre-service) Review decision and make the decision as soon as possible (taking into account the medical exigencies) but no later than twenty-four (24) hours after the request.

For authorizations (Certifications) and denials, the Plan will give telephone notification of the decision to Members, or the Member’s Authorized Representative, Practitioners and those Providers involved in the provision of the service within twenty-four (24) hours of receipt of the request. The Plan will give written or electronic notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service as soon as possible but no later than within 72 hours of the oral notification.

Adverse Benefit Determinations
If the Plan’s determination is an Adverse Benefit Determination, the Plan shall provide written notice in accordance with the Written Notification Process for Adverse Benefit Determinations procedures in this Section. At this point, the Member can request an Appeal of Adverse Benefit Determination. Refer to the “Appeal Procedures” in Section 7 for details.

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

Retrospective (Post-service) Review is used by Sanford Health Plan to review for medical care, including care for behavioral, mental health, and/or substance use disorder services, that have already been utilized by the Member, where such services have not involved a Prospective (pre-service) Review request, and where the review is not limited to the veracity of documentation, accuracy of coding, or adjudication for payment.

The Plan will review the request and make the decision to approve or deny within thirty (30) calendar days of receipt of the request. Written or electronic notification will be made to the Member, Practitioner and those Providers involved in the provision of the service within thirty (30) calendar days of receipt of the request.

If the Utilization Management Department is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to fourteen (14) calendar days. Within thirty (30) calendar days of the request for review, Sanford Health Plan will notify the Member or Member’s Authorized Representative of the need for an extension and the date by which it expects to make a decision. The Plan will issue and carry out its determination as expeditiously as the Member’s medical condition requires and no later than the date on which the extension expires.

Lack of Necessary Information
If the Utilization Management Department is unable to make a decision due to lack of necessary information, it will notify the Member or the Member’s Authorized Representative of what specific information is necessary to make the decision within thirty (30) calendar days of the retrospective (post-service) review request. Sanford Health Plan will give the Member or the Member’s Authorized Representative forty-five (45) calendar days to provide the specified information. In lieu of notifying the Member, the Plan can notify the Practitioner/Provider of the information needed if the request for health care services came from the Practitioner/Provider.

Timeframe Extensions
from the date of the notification to the Member, Practitioner or Provider as applicable, until the earlier of the date on which the Plan receives any information from the Member, Practitioner, or Provider or forty-five (45) calendar days after the notification to the Member, Practitioner or Provider. A decision and written or electronic notification to the Member, Practitioner and those Providers involved in the provision of the service will be made within fourteen (14) calendar days of that date. If the information is not received by the end of the forty-five (45) calendar day extension, Sanford Health Plan will issue an Adverse Benefit Determination, and written or electronic notification will be made to the Member, Practitioner and those Providers involved in the provision of the service within fourteen (14) calendar days.

Adverse Benefit Determinations
If the Plan’s determination is an Adverse Benefit Determination, the Plan shall provide written notice in accordance with the Written Notification Process for Adverse Benefit Determinations procedure below. At this point, the Member can request an Appeal of Adverse Benefit Determination. Refer to the “Appeal Procedures” in Section 7 for details.
Written Notification Process for Non-Covered Service and Adverse Benefit Determinations

The written notifications for Non-Covered Service and Adverse Benefit Determinations will include the following:

1. The specific reason for the Adverse Benefit Determination in easily understandable language;
2. Reference to the specific internal plan rule, provision, guideline, or protocol on which the determination was based and notification that the Member will be provided a copy of the actual plan provisions, guidelines, and protocols free of charge upon request. Reasons for any denial of reimbursement or payment for services with respect to benefits under the Plan will be provided within 30 calendar days of a request;
3. If the Adverse Benefit Determination is regarding coverage for a mental health and/or substance use disorder, a statement notifying Members of their opportunity to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not be (and is not) considered a request for an internal Appeal or External Review;
4. If the Adverse Benefit Determination is based in whole or in part upon the Member failing to submit necessary information, the notice shall include a description of any additional material or information which the Member failed to provide to support the request, including an explanation of why the matter is necessary;
5. If the Adverse Benefit Determination is based on medical necessity or an Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the Plan to the Member’s medical circumstances, or a statement that an explanation will be provided to the Member free of charge upon request;
6. For Mental Health and/or Substance Use Disorder (MH/SUD) Adverse Benefit Determinations, if information on any medical necessity criteria is requested, documents will be provided for both MH/SUD and medical/surgical benefits within 30 calendar days of a Member/Member's Authorized Representative/Provider's request. This information will include documentation of processes, strategies, evidentiary standards and other factors used by the plan, in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
7. If the Adverse Benefit Determination is based on medical necessity, a written statement of clinical rationale, including clinical review criteria used to make the decision if applicable. If the denial is due to a lack of clinical information, a reference to the clinical criteria that have not been met will be included in the letter. If there is insufficient clinical information to reference a specific clinical practice guideline or policy, the letter will state the inability to reference the specific criteria and will describe the information needed to render a decision;
8. Notification and instructions on how the Practitioner/Provider can contact the Physician and/or other appropriate Practitioners to discuss the determination;
9. A written statement of clinical rationale, including clinical review criteria used to make the decision if applicable;
10. A description of the Plan’s Appeal procedures including how to obtain an expedited review if necessary (and any time limits applicable to those procedures), the right to submit written comments, documents or other information relevant to the Appeal; an explanation of the Appeal process including the right to Member representation; how to obtain an Expedited review if necessary and any time limits applicable to those procedures; notification that Expedited External Review can occur concurrently with the internal Appeal process for Urgent care/ongoing treatment; and the timeframe the Member has to make an Appeal and the amount of time the Plan has to decide it (including the different timeframes for Expedited Appeals);
11. If the Adverse Benefit Determination is based on medical necessity, notification and instructions on how the Practitioner/Provider can contact the Physician or appropriate Practitioner to discuss the determination.
12. For decisions not wholly in the Member’s favor, the Member has the right to request a State Fair Hearing; the written decision for the External Appeal review will contain the following information:
   a. Instructions to request a State Fair Hearing within one hundred and twenty (120) days from the date of the written Adverse Benefit Determination notice with the following conditions:
      i. The Member has completed the Internal Appeal process through Sanford Health Plan with the Adverse Benefit Determination being upheld, or
      ii. Sanford Health Plan has failed to adhere to the notice and timing requirements of the Internal Appeal process which then the Member is deemed to have exhausted the Plan's appeal process;
   b. How the Member or their representative may request a State Fair Hearing;
   c. The right to continue to receive benefits pending a hearing with the following conditions:
      i. The Appeal is filed in a timely manner,
      ii. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment,
      iii. The services were ordered by an authorized Provider,
      iv. The period covered by the original authorization has not expired, and
      v. The Member requests the extension of benefits;
   d. How to request the continuation of benefits while an Appeal is pending; and
   e. A statement saying if the Plan’s action is upheld in a hearing, the Member may be liable for the cost of the cost of services furnished while the Appeal was pending.
   f. Requests for a State Fair Hearing can be made to:
      Appeals Supervisor, Legal Advisory Unit
      N.D. Department of Human Services
      600 E Boulevard Avenue, Dept. 325
      Bismarck, ND 58505-0250
Phone: (701) 328-2311
Toll-Free: (800) 472-2622
ND Relay TTY: (800) 366-6888 (toll-free)
Email: dhslau@nd.gov

g. Non-Covered Service Determinations are not eligible for State Fair Hearing requests.
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Section 4(a) Medical services and supplies provided by health care professionals

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

- This Certificate of Coverage, including your application for coverage and any amendments, constitutes your entire contract of insurance.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 3, How you get care, for valuable information about conditions for coverage.
- You or your Physician must get pre-authorization (Certification) of some services in this Section. The benefit description will say "NOTE: Certification is required for certain services. Failure to get Certification will result in a reduction or denial of benefits (See Services requiring Certification in Section 3)."

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**Benefit Description**

**Diagnostic and treatment services benefit**

Diagnostic and treatment services are covered when they are professional services from Physicians, nurse practitioners, and Physician’s assistants; in Physician’s office, an acute care center, medical office consultations, and second surgical opinions.

**NOTE:** You or your Physician must get Certification for the following services; Failure to get Certification will result in a reduction or denial of benefits (See Services requiring Certification in Section 3):

1. Second opinions are covered at no cost to the Member from a qualified in-network health care professional, and/or the arrangement for the Member to obtain one out-of-network if a there is not a doctor available In-Network.
2. Second opinions by an Out-of-Network Provider must be Prior Authorized by the Plan. If Out-of-Network second opinions are authorized by the Plan, they are provided at no cost to the Member at the In-Network benefit level.

**Lab, x-ray and other diagnostic tests benefit**

Coverage includes:

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

**Not Covered: Thermograms or thermography**

**Telehealth, e-visit, and video visits benefit**

Per Sanford Health 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
Preventive care benefit

Preventive Care coverage is as follows:
As outlined in the Plan Preventive Health Guidelines, the following preventive services under the ACA received from an In-Network Provider are covered without any copayment requirement that would otherwise apply:
1. Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force including but not limited to colonoscopies, prostate screening, mammograms, and total blood cholesterol;
2. Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Member involved;
3. With respect to covered persons who are age 19 or 20, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to covered persons who are women, such additional preventive care and screenings not described above as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. You do not need prior authorization from the Plan or any other person in order to obtain access to obstetrical and/or gynecological care through a participating Provider. To view the Plan’s Preventive Health Guidelines, visit www.sanfordhealthplan.com.

Not Covered:
• Sports physicals, pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver’s licenses)
• Virtual colonoscopies.

Tobacco cessation treatment benefit

Tobacco cessation treatment coverage is as follows:
As defined in the Affordable Care Act, Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force when received from an In-Network Provider are covered without payment requirements that would otherwise apply. Tobacco-cessation treatment includes:
• Screening for tobacco use; and
• At least two (2) tobacco-cessation attempts per year (for Members who use tobacco products). Covering a cessation attempt is defined to include coverage for:
  o Four (4) tobacco-cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and
  o All Food and Drug Administration (FDA)-approved tobacco-cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care Provider without prior authorization.

Not Covered: Hypnosis and Acupuncture

Early Periodic Screening, Diagnosis and Treatment benefit for Members ages 19 and 20

Early Screening, Diagnosis, and Treatment coverage is as follows:
Coverage is provided for preventive, routine, and necessary medical care to correct or ameliorate a condition for Members age 19 or 20 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Federal regulations require ND Medicaid Expansion Members ages 19 or 20 to be informed of the ND Health Tracks Program which offers a comprehensive screening by a medical professional with referrals made to doctors, dentists, and/or other specialist for diagnosis/treatment if any problems or concerns are identified. To schedule an appointment for a Health Tracks Screening, contact your local county social service office.
• EPSDT benefits include the following diagnostic and treatment services:
  a. Screening Services include periodic wellness examinations that include physical and mental health assessments.
  b. Vision services include screening, diagnosis, and treatment for defects in vision. See Vision services (testing, treatment, and supplies) later in this Section for details.
  c. Dental services include screening, relief of pain and infections, restoration of teeth and maintenance of dental health. Coverage includes regular preventive dental care and treatment. See Section 4(f) Dental benefits for details.
  d. Hearing services include screening, diagnosis and treatment for defects in hearing, including the provision of hearing aids or implants if medically necessary (prior authorization (certification) required).
e. When a Practitioner or Provider shows that a Member ages 19 or 20 might have a health problem, related diagnostic testing and evaluations will be provided under EPSDT at no cost. Also included are any necessary referrals so that the Member receives all medically necessary treatment.

- Benefits provided under EPSDT terminate at the end of the month in which the Member reaches age twenty-one (21).
- For information specific to mental health and substance use disorder treatment under EPSDT, see Section 4(d).

Maternity care benefit

Maternity coverage is as follows:

During your pregnancy, you have the choice to remain enrolled with ND Medicaid Expansion through Sanford Health Plan or you can transition to ND Traditional Medicaid. For additional information about this option, please contact your local county social service office. If you do not contact your local county social service office to switch to ND Traditional Medicaid, you will remain covered under with ND Medicaid Expansion.

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

Covered maternity screenings include:

- Screening for gestational diabetes mellitus during pregnancy
  - Testing includes a screening blood sugar followed by a glucose tolerance test if the sugar is high.
- Prenatal vitamins
- Anemia screening
- Bacteruria (bacteria in urine) screening
- Hepatitis B screening
- Rh (Rhesus) incompatibility screening: first pregnancy visit and 24-28 weeks gestation
- Genetic counseling or testing that has, in effect, a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force. Prior authorization is required.
- Preeclampsia prevention
- Maternal Depression Screening after delivery for mothers who are ages 19 and 20

Breastfeeding support, supplies, and counseling are covered in the following manner: The Plan will cover one breast pump (electric or manual, non-hospital grade) per pregnancy. Replacement tubing, breast shields, and splash protectors are also covered. Bottles, breast milk storage bags, and supplies related to bottles are NOT covered. Pumps and supplies are covered only when obtained from a Sanford Health Plan Participating durable medical equipment Provider. This does NOT include drugstores or department stores. In addition to pumps, consultation with a lactation (breastfeeding) specialist is also covered.

Maternity care includes prenatal through postnatal maternity care and delivery, and care for complication of pregnancy of mother. We cover up to four (4) routine ultrasounds per pregnancy to determine fetal age, size, and development, per Plan guidelines. The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of forty-eight (48) hours for a vaginal delivery to a minimum of ninety-six (96) hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Practitioner/Provider, after consulting with the Member, determines that the Member meets certain criteria and that such discharge after delivery is medically appropriate. If the inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the Member by Participating Practitioners/Providers competent in postpartum care.

NOTE: We encourage you to participate in our Healthy Pregnancy Program; Call (888) 315-0884 (toll-free) or TTY/TDD: (877) 652-1844 (toll-free) to enroll.

Not Covered:
- Amniocentesis or chorionic villi sampling (CVS) solely for sex determination
- Bottles, breast milk storage bags and supplies related to bottles
- Breastfeeding pumps and supplies obtained from drugstores or department stores

Newborn exclusion

This Certificate of Coverage does not cover newborns. A newborn infant may be eligible to be covered by the North Dakota Children’s Health Insurance Program from birth. Sanford Health Plan is required to notify the North Dakota Department of Human Services Division of Medical Services of the birth of the newborn within the time period required under the Medicaid Agreement.

Family planning and contraceptive services benefit

NOTE: If you would like to receive family planning services from a Non-Participating Provider, you must get Certification of these services; Failure to get Certification will result in a denial of benefits.

Family planning coverage is as follows:

- Family Planning Services including consultations and pre-pregnancy planning.
- Barrier methods: diaphragm and cervical cap fitting and purchase.
- Implantable devices. Placement and removal is covered once every five (5) years or as medically necessary.
Sterilizations:
- Medical – Occlusion of the fallopian tubes by use of permanent implants.
- Surgical – Tubal ligation covered at 100% of allowed only when performed as the primary procedure. When performed as part of a cesarean section (C-section) delivery, it will be covered as a medical benefit with the applicable cost-sharing applied.
- Voluntary sterilizations, including vasectomies
- Voluntary sterilizations administered in an outpatient clinical setting or during an office visit, including injectable medroxyprogesterone acetate, are covered at 100% (no cost), per Plan guidelines and Medical Necessity criteria.

Not Covered:
- Genetic counseling or testing except for services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force; prior authorization (Certification) is required.
- Reproductive Health Care Services prohibited by the laws of this State
- Elective abortion services
- Reversal of voluntary sterilization

Infertility services benefit

Infertility benefits coverage is as follows:

Not Covered:
- Treatment of infertility, including artificial means of conception such as:
  - Artificial insemination, in-vitro fertilization, ovum or embryo placement or transfer, or gamete intra-fallopian tube transfer.
- Cryogenic or other preservation techniques used in such or similar procedures;
- Infertility medication;
- Any other services or supplies related to artificial means of conception;
- Reversals of prior sterilization procedures; and/or
- Any expenses related to surrogate parenting or surrogate pregnancies

Allergy care benefit

Allergy care coverage is as follows:
- Testing and treatment
- Allergy injections
- Allergy serum

Not Covered: Provocative food testing and sublingual allergy desensitization

Amino acid-based elemental oral formulas benefit

Amino acid-based elemental oral formula coverage is as follows:
- Coverage for medical foods and low-protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.

Not Covered:
- Dietary desserts and snack items
- Low protein modified food products or medical food for PKU to the extent those benefits are available under a Department of Health program or other state agency

Phenylketonuria (PKU) benefit

Phenylketonuria Coverage is as follows:
- Testing, diagnosis and treatment of Phenylketonuria and inherited metabolic diseases of amino acid or organic acid including dietary management, medical foods and low-protein modified food products determined by a physician to be medically necessary, formulas, Case Management, intake and screening, assessment, comprehensive care planning and service referral.

Not Covered:
- PKU Dietary desserts and snack items
- Low protein modified food products or medical food for PKU to the extent those benefits are available under a Department of Health program or other state agency

Chiropractic services benefit

Chiropractic service coverage is as follows:
- Non-Surgical Spinal treatment and chiropractic services
- Limited to twenty (20) visits each Calendar Year, regardless of whether performed by a chiropractor or other licensed Provider authorized to perform such services
Not Covered: Vitamins not otherwise listed as Covered under this Certificate of Coverage; minerals; therabands; cervical pillows; traction services; and hot/cold pack therapy including polar ice therapy and water circulating devices

### Dialysis benefit

Dialysis coverage is as follows:
- Dialysis for renal disease, unless or until the Member qualifies for federally funded dialysis services under the End Stage Renal Disease (ESRD) program.
- Services include equipment, training, and medical supplies required for effective dialysis care. Coordination of Benefit Provisions apply; see Section 8.

Not Covered: Dialysis services received without Prior-certification from Non-Participating Providers when traveling out of the Service Area

### Diabetes supplies, equipment, and education benefit

NOTE: Indicated Durable Medical Equipment (DME) requires Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 3.)

**Diabetic Services coverage is as follows:**
- Blood glucose monitors including continuous glucose monitoring systems (CGM). *This is a DME that requires Certification*
- Blood glucose monitors for the legally blind
- Test strips for glucose monitors
- Urine testing strips
- Insulin pumps and all supplies for the pump. *This is a DME that requires Certification*
- Custom diabetic shoes and inserts limited to one (1) pair of depth-inlay shoes and three (3) pairs of inserts; or one (1) pair of custom molded shoes (including inserts) and three (3) additional pairs of inserts

- Insulin injection aids
- Lancets and lancet devices
- Syringes
- Insulin infusion devices. *This is a DME that requires Certification*
- Prescribed oral agents for controlling blood sugars
- Glucose agents
- Glucagon kits
- Insulin measurement and administration aids for the visually impaired and other medical devices for the treatment of diabetes
- Routine foot care including toe nail trimming

**Diabetes self-management training and education shall only be covered if:**
- the service is provided by a Physician, nurse, dietitian, pharmacist or other licensed health care Practitioner/Provider who satisfies the current academic eligibility requirements of the National Certification Board for Diabetic Educators and has completed a course in diabetes education and training or has been certified by a diabetes educator; and
- the training and education is based upon a diabetes program recognized by the American Diabetes Association or a diabetes program with a curriculum approved by the American Diabetes Association or the North Dakota Department of Health.

Not Covered: Food items for medical nutrition therapy

### Durable medical equipment (DME) benefit

Durable medical equipment (DME) coverage is as follows:
- Covered DME equipment prescribed by an attending Physician, which is Medically Necessary, not primarily and customarily used for non-medical purposes, designed for prolonged use, and for a specific therapeutic purpose in the treatment of an illness or injury. Limitations per policy guidelines apply (available upon request).
- Habilitative services, which are health care services and devices that help a person keep, learn, or improve skills and functioning for daily living, are covered. [45 CFR §156.115 (a) (5) (i)]
- Casts, splints, braces, crutches and dressings for the treatment of fracture, dislocation, torn muscles or ligaments and other chronic conditions per Plan guidelines (available upon request).

NOTE: The following DME require Certification; failure to get Certification will result in a reduction or denial of benefits (See Services requiring Certification in Section 3):

- a. Airway Clearance Device
- b. Beds such as Hospital beds and mattresses
- c. Communication Device
- d. Continuous Glucose Monitors and Sensors
- e. Cranial Molding Helmet
- f. Dental Appliances
- g. Home INR Monitor
- h. Insulin Pump
- i. Selected Orthotics
- j. Phototherapy UVB Light Device
- k. Pneumatic Compression with external pump
- l. Prosthetic Limb

Not Covered:
- Home Traction Units
- Orthopedic shoes; custom made orthotics; over-the-counter orthotics and appliances
- Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage
• Revision of durable medical equipment, except when made necessary by normal wear or use
• Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness; or if lost or stolen
• Duplicate or similar items
• Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates
• Items, which are primarily educational in nature, or for vocation, comfort, convenience or recreation
• Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools
• Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas
• Home Modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment
• Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier
• Remote control devices as optional accessories

**Implants/Stimulators benefit**

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

**NOTE:** The following Implants/Stimulators require Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval (Certification) in Section 3.):
• Bone Growth (external)
• Cochlear Implant (Device and Procedure)
• Deep Brain Stimulation
• Gastric Stimulator
• Spinal Cord Stimulator (Device and Procedure)
• Vagus Nerve Stimulator

**Foot care benefit**

Foot care coverage is as follows:
• For Members with diabetes only: routine foot care. See Diabetes supplies, equipment, and education in this Section for more information.
• Non-routine diagnostic testing and treatment of the foot due to illness or injury.

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

**Not Covered:**
• Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized corrective surgery (unless otherwise listed as Covered under this Certificate of Coverage)
• Diagnosis and treatment of weak, strained, or flat feet

**Home health services benefit**

**NOTE:** Certification is required for the services in this subsection; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 3.)

Home health services coverage is as follows:
The following is covered, if approved by the Plan in lieu of a Hospital or Skilled Nursing Facility stay:
• part-time or intermittent care by a RN or LPN/LVN
• part-time or intermittent home health aide services for direct patient care only
• physical, occupational, speech, inhalation, and intravenous therapies up to the maximum benefit allowable
• medical supplies, prescribed medicines, and lab services, to the extent they would be covered if the Member were Hospitalized
• limited to 40 visits in a calendar year and does not include meals, custodial care or housekeeping
• one (1) home health visit constitutes four (4) hours of nursing care

**PERSONAL CARE SERVICES FOR MEMBERS AGES 19 AND 20 (pre-authorization/certification required)**

Medically necessary personal care services or home help services necessary to correct or ameliorate a medical condition when provided as part of an approved treatment plan and is directly related to the need for skilled nursing care.

**Not Covered:**
• Nursing care requested by, or for the convenience of the Member or the Member’s family (rest cures)
• Custodial or convalescent care

**Orthotic and prosthetic devices benefit**

**NOTE:** Indicated Durable Medical Equipment (DME) requires Certification; failure to get Certification may result in a reduction or denial
Hearing services

- External hearing aids for the treatment of a hearing loss that is not due to the gradual deterioration that occurs with aging and/or other lifestyle factors. This is a DME that requires Certification. Benefit is limited to one hearing aid, per ear, per Member, every three (3) years, in alignment with medical necessity and Plan guidelines.
- Cochlear implants and bone-anchored (hearing-aid) implants. This is an Implant/Stimulator that requires Certification. Also, see Implants/Stimulator coverage in this Section for additional benefit information.
- Cochlear implants and bone-anchored (hearing-aid) implants. This is an Implant/Stimulator that requires Certification. Also, see Implants/Stimulator coverage in this Section for additional benefit information.

Physical, cardiac, speech and occupational therapies

- Outpatient Rehabilitative Therapy (Physical Therapy, Occupational Therapy, Speech Therapy and Cardiac Rehabilitative services directed at improving physical functioning of the Member) which is expected to provide significant improvement within two (2) months, as certified on a prospective and timely basis by the Plan.
- Coverage is provided for habilitative services, which include the management of limitations and disabilities, including services or programs that help maintain or prevent deterioration in physical, cognitive, or behavioral function. See "Durable Medical Equipment (DME)" in this Section for coverage of devices related to habilitative services.
- Services must be provided in accordance with a prescribed plan of treatment ordered by a Practitioner/Provider. Benefits are not available for Maintenance Care.
- Coverage is limited to thirty (30) visits per therapy per Calendar Year for Members ages 21 and older.
- Includes one-to-one water therapy

Not Covered:

- Traction services
- Educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)
- Physical, occupational, or speech therapy Maintenance Care that is typically long-term, by definition not therapeutically necessary
- Services provided in the Member’s home for convenience
- Hot/cold pack therapy including polar ice therapy and water circulating devices
- Speech therapy for the purpose of correcting speech impediments (stuttering or lisps) for Members ages 21 and older
- Voice training and voice therapy

Hearing services (testing, treatment, and supplies) benefit

- Sudden sensorineural hearing loss (SSNHL), and diagnostic testing and treatment related to acute illness or injury.

NOTE: Indicated Durable Medical Equipment (DME) and Implant/Stimulators require Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 3)

1. External hearing aids for the treatment of a hearing loss that is not due to the gradual deterioration that occurs with aging and/or other lifestyle factors. This is a DME that requires Certification. Benefit is limited to one hearing aid, per ear, per Member, every three (3) years, in alignment with medical necessity and Plan guidelines.
2. The provision of hearing aids must meet criteria for rehabilitative and/or habilitative services coverage and either:
   a. provide significant improvement to the Member within two (2) months, as certified on a prospective and timely basis by the Plan; or
   b. help maintain or prevent deterioration in physical, cognitive, or behavioral function.
3. Cochlear implants and bone-anchored (hearing-aid) implants. This is an Implant/Stimulator that requires Certification. Also, see Implants/Stimulator coverage in this Section for additional benefit information.
Additional hearing services (testing, treatment, and supplies) covered for Members ages 19 and 20

- Diagnostic testing and treatment of hearing loss
- Medically necessary hearing-related supplies, purchases, examinations, or testing to correct hearing impairment or loss, including hearing aids (external), non-implant devices, and/or other equipment (Prior authorization required)
- Cochlear implants and bone-anchored (hearing aid) implants (Prior authorization required)

Not Covered:
- Treatment of gradual deterioration of hearing that occurs with aging and/or other lifestyle factors, and related adult hearing screening services, testing and supplies for Members ages 21 and older
- External hearing aids, non-implant devices, or equipment to correct gradual hearing impairment or loss that occurs with aging and/or other lifestyle factors for Members ages 21 and older
- Tinnitus Maskers
- All other hearing-related supplies, purchases, examinations, testing or fittings
- For Members ages 19 and 20: Hearing-related supplies, purchases, examinations, or testing that are not Medically Necessary

Vision Services coverage is as follows:

- Non-routine vision exams relating to acute disease or injury of the eye
- For Members with Aphakia (the absence of the lens of the eye, due to surgical removal, a perforated wound or ulcer, or a congenital condition resulting in complications which include the detachment of the vitreous or retina, and glaucoma):
  - Maximum benefit allowance of one pair of eyeglasses, including lenses and one frame per Member per lifetime. If the frame breaks, the Plan will cover the cost for a new frame if not due to Member abuse or misuse; or
  - Maximum benefit allowance of two (2) single clear contact lenses for the aphakia eye per Member per calendar year.
- Scleral Shells: Soft shells limited to two (2) per Member per calendar year. Hard shells limited to one (1) per Member per lifetime.
- Dilated eye examination for diabetes-related diagnosis (limit of one (1) exam per Member per calendar year)

Additional vision services covered for Members ages 19 and 20

**VISION EXAMS FOR MEMBERS AGES 19 AND 20**
One routine vision examination is covered annually; coverage includes:
- Refraction and glaucoma screening (tonometry test);
- Dilated eye examination for diabetes-related diagnosis;

**PRESCRIBED LENSES AND FRAMES FOR MEMBERS AGES 19 AND 20**
- One pair of eyeglasses, including lenses and one frame are covered every other benefit (calendar) year
- Prescribed lenses are covered once per Member every benefit (calendar) year for prescribed single vision, bifocal or trifocal lenses, including directly related professional services.
- Coverage for frames limited to once every other calendar year; coverage for eyeglass lenses limited to once per Member per benefit (calendar) year.
- Coverage for contact lenses in lieu of the prescribed lenses benefit once per Member every benefit (calendar) year.

**POST-OPERATIVE REFRACTIVE EXAMINATION(S) FOR MEMBERS AGES 19 AND 20**
Coverage is provided for a post-operative refractive examination(s) when used instead of the benefits listed above. The annual vision examination, refraction, single vision lenses and frames must be available in order for a post-operative refractive examination(s) benefit to be available. If the Member uses the vision benefit for a post-operative refractive examination(s), additional benefits for vision examinations and refractions, lenses and frames, or contact lenses will not be allowed until the next calendar year.

Not Covered:
- For Members ages 21 and older: routine vision exams, vision services, and supplies, except as specified as Covered in this Certificate of Coverage
- The replacement of lost or broken lenses or frames unless at the time of replacement the Member is eligible for prescribed lenses or frames
- Charges for cosmetic attachments to lenses or frames including but not limited to: monograms or facets, roll or polish edges for rimless lenses, tinting of lenses; i.e. photogray for glass lenses and transition for plastic lenses, slimlite or hi-index lenses, polythin or polycarbonate lenses, oversized lenses; i.e. large or oversize goggle blanks, highpower, specialty lenses; i.e. Smart Seq., executive, bifocal or trifocal extra wide
- Visual field exams
- Sunglasses
- Safety lenses
- Protective or scratch coating for plastic lenses
- Slab-off lenses
- Services or supplies determined by the Plan to be special or unusual, including orthoptics, vision training and vision aids
- Contact lens cleaning supplies
• Contact lens fitting fee
• Pre- and post-operative refractive services except as specified in this Certificate of Coverage
• Radial Keratotomy, Myopic Keratomileusis, and any surgery involving corneal tissue for the purpose of altering, modifying, or correcting myopia, hyperopia, or stigmatic error for Members ages 21 and older
• Routine cleaning of Scleral Shells
• Services considered experimental or investigational that are not part of an Approved Clinical Trial
• Dispensing fees for a Member who is not eligible for lenses and/or frames within 1 (one) year
• Services that the Provider did not personally provide

Clinical Trials benefit

NOTE: This requires Certification; failure to get Certification may result in a reduction or denial of benefits. (See Services requiring Preauthorization/Prior Approval in Section 3)

Clinical trial benefits are as follows:
Clinical Trials are covered as Routine Patient Costs when provided as part of an Approved Clinical Trial if the services are otherwise Covered Services. An In-Network Participating Practitioner and/or Provider must provide Sanford Health Plan notice of a Member’s participation in an Approved Clinical Trial.

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

Not covered:
• Extra care costs related to taking part in an Approved Clinical Trial such as additional tests that a Member may need as part of the trial, but not as part of the Member’s routine care.
• Research costs related to conducting the Approved Clinical Trial such as research Physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the Approved Clinical Trial; Sanford Health Plan does not cover these costs.

Other medical benefit treatment therapies not specified elsewhere

Treatment therapy is as follows:
• Inhalation Therapy
• Radiation Therapy. This is an Oncology Service/Treatment that requires Certification.
• Chemotherapy, including oral chemotherapy drugs. This is an Oncology Service/Treatment that requires Certification.
• Pheresis Therapy
• 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).

Not Covered:
• Non-surgical treatments that do not meet the Plan’s medically necessary guidelines (available upon request)
• Treatment received outside of the United States
Here are some important things you should keep in mind about these benefits:

- This Certificate of Coverage, including your application for coverage and any amendments, constitute your entire contract of insurance.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.
- Participating Providers must provide or arrange your care and you must be hospitalized in a Network Facility.
- Mental Health and Substance Use Disorder benefits provided by a Hospital or other Facility are outlined in Section 4(d).
- Be sure to read Section 3, How you get care, for valuable information about conditions for coverage.
- **YOU MUST GET PRE-AUTHORIZATION (CERTIFICATION) FOR SOME OF THESE SERVICES.** See the benefit description below.

### Benefit Description

#### Admissions benefit

**NOTE:** Certification is required for the services in this subsection; failure to get Certification will result in a reduction or denial of benefits. *(See Services requiring Certification in Section 3.)*

**Admission coverage is as follows:**

The following Hospital Services are covered:

- Room and board
- Critical care services
- Use of the operating room and related facilities
- General Nursing Services, including special duty Nursing Services, if approved by the Plan
- The administration of whole blood and blood plasma is a Covered Service. The purchase of whole blood and blood components is not covered unless such blood components are classified as drugs in the United States Pharmacopoeia.
- Special diets during Hospitalization, when specifically ordered
- Other services, supplies, biologicals, drugs and medicines prescribed by a Physician during Hospitalization

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

**Not Covered:**

- Take-home drugs (outpatient drugs given to the Member at discharge)
- Personal comfort items (telephone, television, guest meals and beds)
- Admissions to Hospitals performed only for the convenience of the Member, the Member’s family or the Member’s Physician or other Practitioner/Provider
- Custodial care
- Convalescent care
- Intermediate level or domiciliary care
- Rest cures
- Services to assist in activities of daily living

#### Outpatient hospital or ambulatory surgical center benefit

**NOTE:** Certification is required for the services in this subsection; failure to get Certification will result in a reduction or denial of benefits. *(See Services requiring Certification in Section 3.)*

**Outpatient Hospital or Ambulatory Surgical Center Coverage is as follows:**

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

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

**Not Covered:**

- Surgical procedures that can be done, and are otherwise covered, in a Physician office setting (i.e. vasectomy, toe nail removal)
- Blood and blood derivatives replaced by the Member
- Take-home drugs (outpatient drugs given to the Member at discharge)
**Skilled nursing facility services benefit**

**NOTE:** Certification is required for the services in this subsection; failure to get Certification will result in a reduction or denial of benefits. *(See Services requiring Certification in Section 3.)*

**Skilled Nursing Facility coverage is as follows:**
- Skilled Nursing Facility Services are covered if approved by the Plan in lieu of continued or anticipated Hospitalization.
- The following Skilled Nursing Facility Services are covered when provided through a state licensed nursing Facility or program:
  a. Skilled nursing care, whether provided in an inpatient skilled nursing unit, a skilled nursing Facility, or a subacute (swing bed) facility
  b. Room and board in a skilled nursing Facility
  c. Special diets in a skilled nursing Facility, if specifically ordered
- Skilled nursing Facility care services are limited to thirty (30) days in a consecutive twelve (12) month period.
- Skilled nursing care in a Hospital shall be covered if the level of care needed by a Member has been reclassified from acute care to skilled nursing care and no designated skilled nursing care beds or swing beds are available in the Hospital or in another Hospital or health care Facility within a thirty-mile (30) radius of the Hospital.

**Not Covered:**
- Custodial Care
- Convalescent care
- Intermediate level or domiciliary care
- Residential care
- Rest cures
- Services to assist in activities of daily living

**Hospice care benefit**

**NOTE:** Hospice care requires an Admission and needs Certification for the services in this subsection; failure to get Certification will result in a reduction or denial of benefits. *(See Services requiring Certification in Section 3.)*

**Hospice Care coverage is as follows:**
A Member may elect to receive hospice care, instead of the traditional Covered Services provided under the Plan, when the following circumstances apply:
- The Member has been diagnosed with a terminal disease and a life expectancy of six (6) months or less;
- The Member has chosen a palliative treatment focus (i.e. emphasizing comfort and support services rather than treatment attempting to cure the disease or condition);
- The Member continues to meet the terminally ill prognosis as reviewed by the Plan’s Chief Medical Officer or designee over the course of care; and
- The hospice service has been approved by the Plan.

**The following Hospice Services are Covered Services:**
- Admission to a hospice Facility, Hospital, or skilled nursing Facility for room and board, supplies and services for pain management and other acute/chronic symptom management
- In-home hospice care per Plan guidelines (available upon request)
- Part-time or intermittent nursing care by a RN, LPN/LVN, or home health aide for patient care up to eight (8) hours per day
- Social services under the direction of a Participating Provider
- Psychological and dietary counseling
- Physical or occupational therapy, as described under Section 4(a)
- Consultation and Case Management services by a Participating Provider
- Medical supplies, DME and drugs prescribed by a Participating Provider
- Expenses for Participating Providers for consultant or Case Management services, or for physical or occupational therapists, who are not group Members of the hospice, to the extent of coverage for these services as listed in Section 4(a), but only where the hospice retains responsibility for the care of the Member

**Not Covered:** Independent nursing, homemaker services, respite care

**Reconstructive surgery benefit**

**NOTE:** The following services are considered Outpatient Surgery and require Certification; failure to get Certification will result in a reduction or denial of benefits. *(See Services requiring Certification in Section 3.)*

**Reconstructive surgery coverage is as follows:**
- Surgery to restore bodily function or correct a deformity caused by illness or injury
- Coverage for mastectomy related benefits are provided in a manner determined in consultation with the attending physician and Member. Coverage will be provided for reconstructive breast surgery and physical complications at all stages of a mastectomy, including lymphedema for those Members who had a mastectomy resultant from a disease, illness, or injury. For single mastectomy: coverage
extends to the non-affected side to make it symmetrical with the affected breast post-surgical reconstruction. Breast prostheses and surgical bras and replacements are also covered (see Prosthetic devices in Section 4(a)).

**Not Covered:**
- Surgical placement of non-covered prosthetics
- Cosmetic Services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member’s appearance and not medically necessary, including but not limited to, breast augmentation, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services
- Removal, revision, or re-implantation of saline or silicone implants for: breast implant malposition; unsatisfactory aesthetic outcome; Member desire for change of implant; Member fear of possible negative health effects; or removal of ruptured saline implants that do not meet medical necessity criteria.
- Prophylactic (preventive) mastectomy

### Oral and maxillofacial surgery benefit

**NOTE:** Indicated services are considered Outpatient Surgery, Services or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 3.)

**Oral and maxillofacial surgery coverage is as follows:**
- Oral surgical procedures limited to services required because of injury, accident, or cancer that damages Natural Teeth. *This is an Outpatient Surgery that requires Certification.*
  - Care must be received within six (6) months of the occurrence
  - Associated radiology services are included
  - “Injury” does not include injuries to Natural Teeth caused by biting or chewing
  - Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Orthognathic Surgery per Plan guidelines. *This is an Outpatient Surgery that requires Certification*
  - Associated radiology services are included
  - Coverage applies regardless of whether the services are provided in a Hospital or a dental office
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
  - Services for the Treatment and Diagnosis of TMJ/TMD are covered subject to Medical Necessity defined by Sanford Health Plan’s Medical coverage guidelines
  - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers
  - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
    - Splint limited to one (1) per Member per benefit period. *This is a DME that requires Certification.*
- Diagnosis and treatment for Craniofacial disorder is covered subject to Medical Necessity defined by Sanford Health Plan’s Medical coverage guidelines
- Anesthesia and Hospitalization charges for dental care are covered for a Member who: *This is an Outpatient Service requires Certification.*
  - is severely disabled or otherwise suffers from a developmental disability; or
  - has a high-risk medical condition(s) as determined by a licensed Physician that places the Member at serious risk.

**Not Covered:**
- Routine dental care and treatment for Members who are ages 21 and older
- Osseointegrated implant surgery (dental implants)
- Removal of wisdom teeth for Members who are ages 21 and older
- Natural teeth replacements including crowns, bridges, braces or implants
- Hospitalization for extraction of teeth except as required by N.D.C.C. § 26.1-36-09.9
- Dental x-rays or dental appliances
- Shortening of the mandible or maxillae for cosmetic purposes
- Services and supplies related to ridge augmentation, implantology, and Preventive vestibuloplasty
- Dental appliances of any sort, including but not limited to bridges, braces, and retainers, except for appliances approved for the treatment of TMJ/TMD

### Transplant benefit

**NOTE:** Certification is required for the services in this subsection; failure to get Prior Authorization will result in a reduction or denial of benefits. (See Services requiring Prior Authorization in Section 3.)

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

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

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

Anesthesia benefit

Coverage is available for services of an anesthesiologist or other certified anesthesia Provider in connection with a Certified inpatient or outpatient procedure or treatment.
Section 4(c) Emergency services/accidents

**Here are some important things to keep in mind about these benefits:**
- This Certificate of Coverage, including your application for coverage and any amendments, constitutes your entire contract of insurance.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 3, *How you get care*, for valuable information about conditions for coverage.

**Benefit Description**

**What is an Emergency Medical Condition?**
An Emergency Medical Condition is the sudden and unexpected onset of a health condition that would lead a prudent layperson acting reasonably and possessing the average knowledge of health and medicine to believe that the absence of immediate medical attention could result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person’s health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

**What is an Urgent Care Situation?**
An Urgent Care Situation is a degree of illness or injury, which is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours, such as stitches for a cut finger. If an Urgent Care Situation occurs, Members should contact their Primary Care Physician immediately, if one has been selected, and follows his or her instructions. A Member may always go directly to a participating acute care or after-hours clinic (available on request or visit www.sanfordhealthplan.com).

**What are Post-Stabilization Services?**
Post-stabilization Services means covered services, related to an Emergency Medical Condition, that are provided after a Member is stabilized in order to maintain the stabilized condition or under the circumstances to improve or resolve the Member’s condition.

The Health Plan covers Emergency services necessary to screen and stabilize Members without Certification in cases where a Prudent Layperson, reasonably believed that an Emergency Medical Condition existed. **All services must be rendered within the United States.**

**Emergency within the Service Area**
Emergency services from Out-of-Network Providers will be covered at the same benefit and cost sharing level as services provided by In-Network Providers. If the Plan determines the condition did not meet prudent layperson definition of an Emergency, then the Out-of-Network benefit exclusion will apply and the Member is responsible for charges above the Maximum Allowed Amount.

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

The Member or a designated relative or friend must notify the Plan and the Member’s Primary Care Physician, if one has been selected, as soon as reasonably possible after receiving treatment for an Emergency Medical Condition, but no later than ten (10) days after the Member is physically or mentally able to do so.

With respect to care obtained from a Non-Participating Provider within the Plan’s Service Area, the Plan shall cover Emergency services necessary to screen and stabilize a Member and may not require Prospective (pre-service) Review of such services if a Prudent Layperson would have reasonably believed that use of a Participating Provider would result in a delay, or if a provision of federal, state, or local law requires the use of a specific Practitioner/Provider. The coverage shall be at the same benefit level as if the service or treatment had been rendered by a Participating Provider.

If a Member is admitted to a Non-Participating Provider, then the Plan will contact the admitting Physician to determine medical necessity and a plan for treatment. In some cases, where it is medically safe to do so, the Member may be transferred to a Participating Hospital. If the Member requires post-stabilization care services to maintain, improve, or resolve the Member’s condition, the Plan shall continue coverage until: (1) a Participating Provider assumes responsibility for the Member’s care; (2) the Plan reaches an agreement with the treating Provider concerning the Member’s care; (3) the Plan has contacted the treating Provider to arrange for a transfer; or (4) the Member is discharged.

**Emergency outside the Service Area**
If an Emergency Medical Condition occurs when traveling outside of the Plan’s Service Area, Members should go to the nearest Emergency Facility to receive care. The Member or a designated relative or friend must notify the Plan and the Member’s Primary Care Physician, if one has been selected, as soon as reasonably possible after receiving treatment for an Emergency Medical Condition, no later than ten (10) days after the Member is physically or mentally able to do so.

Coverage will be provided for Emergency Medical Conditions outside of the Service Area (at the In-Network benefit level) unless the
Member has traveled outside the Service Area for the purpose of receiving such treatment.

NOTE: Coverage for Emergency Medical Conditions is only provided when care is received in the United States. See “No Coverage Outside of the United States” below.

If a Member is admitted to a Non-Participating Provider, then the Plan will contact the admitting Physician to determine medical necessity and a plan for treatment. In some cases, where it is medically safe to do so, the Member may be transferred to a Participating Hospital. If the Member requires post-stabilization care services to maintain, improve, or resolve the Member’s condition, the Plan shall continue coverage until: (1) a Participating Provider assumes responsibility for the Member’s care; (2) the Plan reaches an agreement with the treating Provider concerning the Member’s care; (3) the Plan has contacted the treating Provider to arrange for a transfer; or (4) the Member is discharged.

If an Urgent Care Situation occurs when traveling outside of the Plan’s Service Area, Members should contact their Primary Care Physician immediately, if one has been selected, and follow his or her instructions. If a Primary Care Physician has not been selected, the Member should contact the Plan and follow the Plan’s instructions. Coverage will be provided for Urgent Care Situations outside the Service Area at the In-Network level unless the Member has traveled outside the Service Area for the purpose of receiving such treatment.

NOTE: Coverage in Urgent Care Situations is only provided when services are received in the United States. See “No Coverage Outside of the United States” below.

NO COVERAGE OUTSIDE OF THE UNITED STATES
There is no coverage for Members when traveling outside of the United States. Services both in and out-of-network are only covered by the Plan when provided within the United States. Any costs for health care services received when traveling out of the United States are the sole responsibility of the Member.

NOTE: Out-of-Network Coverage will be provided in the United States for non-Emergency medical care or non-Urgent Care Situations when traveling outside the Plan’s Service Area. Out-of-Network Coverage rules apply unless care is available from a Participating Provider.

Not Covered:

- Emergency care provided outside the Service Area if the need for care could have been foreseen before leaving the Service Area
- Medical and Hospital costs resulting from a normal full-term delivery of a baby outside the Service Area
- Care received outside the United States

Ambulance and emergency transportation services benefit

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

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

Certification is required for:

- Air ambulance services; and
- Non-emergent transportation (see Section 4(g) for details on this benefit)

Not Covered:

- Transfers performed only for the convenience of the Member, the Member’s family or the Member’s Physician or other Practitioner/Provider
Section 4(d) Mental health and substance use disorder benefits

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**Benefit Description**

**Mental health benefit**

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

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

Mental health benefits are covered with the same Copays and restrictions as other medical/surgical benefits under the Plan. Covered services for mental health conditions include:

• Outpatient Professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, or other qualified mental health professionals
• Inpatient Hospitalization
• Medication management
• Diagnostic tests
• Electroconvulsive therapy (ECT)
• Partial Hospitalization
• Intensive Outpatient Programs
• Telepsychiatry (see Section 4(a) for details)

If you are having trouble getting an office visit with a mental health Provider, you can call one of these crisis lines:

**Region I, Williston:**
24-hour Crisis Line: (701) 572-9111
Toll-Free Crisis Line: (800) 231-7724 | TTY: (701) 774-4692

**Region II, Minot:**
24-hour Crisis Line: (701) 857-8500
Toll-Free Crisis Line: (888) 470-6968 | TTY: (701) 857-8666

**Region III, Devils Lake:**
24-hour Crisis Line: (701) 662-5050 [collect calls accepted]
Toll-Free: (888) 607-8610 | TTY: (701) 665-2211

**Region VI, Grand Forks:**
24-hour Crisis Line: (701) 775-0525
Toll-Free: (800) 845-3731

**Region V, Fargo:**
24-hour Crisis Line: (701) 298-4500
Toll-Free: (888) 342-4900

**Region VI, Jamestown:**
24-hour Crisis Line: (701) 253-6304

**Region VII, Bismarck:**
24-hour Crisis Line: (701) 328-8899
Toll-Free: (888) 328-2112

**Region VIII, Dickinson:**
24-hour Crisis Line: (701) 227-7500 (during business hours)
(701) 290-5719 (after business hours)

Telephonic consultation is available for a Member who is diagnosed with depression, and is within twelve (12) weeks of starting antidepressant therapy, per Plan guidelines (available upon request). Coverage limited to one (1) telephonic consult per Member per year for each member, and one (1) telephonic consult for Attention Deficit Hyperactive Disorder (ADHD).
Additional mental health services covered for Members ages 19 and 20

RESIDENTIAL TREATMENT FACILITY SERVICES FOR MEMBERS AGE 19 OR 20 (pre-authorization/certification required)

- Inpatient services, including Room and Board, are covered at Residential Treatment Facilities, regardless of whether or not the facility is an IMD. For information on IMDs, see definitions in Section 10.
- Payment for Room and Board, as well as inpatient coverage for stays at IMDs, will terminate at the end of the month in which the Member reaches age twenty-one (21).

APPLIED BEHAVIORAL ANALYSIS (ABA) THERAPY (pre-authorizations/certification required)

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

- Member must be diagnosed with Autism Spectrum Disorder by a Provider and/or Practitioner qualified to diagnose the condition.
- ABA as behavioral health treatment is expected to result in the achievement of specific improvements in the Member’s functional capacity of their autism spectrum disorder, subject to Plan medical policy and medical necessity guidelines.
- ABA services are only covered when provided by a licensed or certified practitioner as defined by law.
- Coverage of ABA is subject to preauthorization, concurrent review, and other care management requirements.
- Coverage terminates at the end of the month in which the Member reaches age twenty-one (21).

NOTE: These benefits are all Admissions or Outpatient Services that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 3):

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

Not Covered:

- Convalescent care
- Room and board charges for Members ages 21 and over at a Residential Treatment Facility
- Inpatient Treatment for Members ages 21 and over at a Facility that is an Institution for Mental Diseases (IMD)
- Marriage or bereavement counseling, pastoral counseling, financial or legal counseling, and custodial care counseling
- Educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)
- Educational or non-medical services related to learning disabilities, unless medically necessary for Members age 19 or 20
- Services related to environmental change, unless medically necessary for Members age 19 or 20
- Educational or non-medical services related to behavioral therapy, modification, or training
- Applied Behavioral Analysis (ABA) for Members 21 and older
- Milieu therapy
- Sensitivity training

Substance use disorder benefit

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

Substance use disorder benefits are covered with the same Copays and restrictions as other medical/surgical benefits under the Plan. Covered services for substance use disorders include:

- Addiction treatment, including for alcohol, drug-dependence, and gambling issues
- Inpatient Hospitalization
- Medication management
- Diagnostic tests
- Outpatient professional services, including therapy by Providers such as psychiatrists, psychologists, clinical social workers, or other qualified mental health and substance use disorder treatment professionals
- Partial Hospitalization
- Intensive Outpatient Programs
- Telepsychiatry (see Section 4(a) for details)

Additional substance use disorder treatment services covered for Members ages 19 and 20

RESIDENTIAL TREATMENT FACILITY SERVICES FOR MEMBERS AGE 19 OR 20 (pre-authorization/certification required)

- Inpatient services, including Room and Board, are covered at Residential Treatment Facilities, regardless of whether or not the facility is an IMD. For information on IMDs, see definitions in Section 10.
- Payment for Room and Board, as well as coverage for stays at IMDs, will terminate at the end of the month in which the Member reaches age twenty-one (21).
NOTE: These benefits are all Admissions and/or Outpatient Services that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 3):

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

**Not Covered:**

- Confinement Services to hold or confine a Member under chemical influence when no Medically Necessary services are provided, regardless of where the services are received (e.g. detoxification centers)
- Room and board charges for Members ages 21 and over at a Residential Treatment Facility
- Inpatient Treatment for Members ages 21 and over at a Facility that is an Institution for Mental Diseases (IMD)
- Marriage or bereavement counseling, pastoral counseling, financial or legal counseling, and custodial care counseling
- Educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)
- Educational or non-medical services related to learning disabilities, unless medically necessary for Members age 19 or 20
- Services related to environmental change, unless medically necessary for Members age 19 or 20
- Milieu therapy
- Sensitivity training
- Domiciliary care or Maintenance Care
- Convalescent care or Custodial Care
Here are some important things to keep in mind about these benefits:

- **Where you can obtain them.** You must fill the prescription at a Plan Participating pharmacy. If you choose to go to a Non-Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy. Some injectable drugs are obtained through mail order. To enroll and obtain prior-approval to join the Injectable Drugs Program, call (866) 333-9721. Please refer to your Formulary for a complete listing of injectable drugs that require Certification. A listing of Plan Participating pharmacies is available free-of-charge upon request or can be viewed at www.sanfordhealthplan.com.

- **How you can obtain them.** You must present your ID card to the Plan Participating pharmacy, if you do not present your ID card to the Plan Participating pharmacy, you must pay 100% of the costs of the medication to the pharmacy.

- **We use a formulary.** Sanford Health Plan covers prescribed drugs and medications according to our Formulary. A formulary is a list of Prescription Drug Products, which are preferred by the Plan for dispensing to Members when appropriate. This list is subject to periodic review and modifications. Additional drugs may be added or removed from the formulary throughout the year. Sanford Health Plan will notify you of any changes. For a copy of the Plan formulary, you can contact our Pharmacy Management Department toll-free at (855) 263-3547 | TTY/TDD: (877) 652-1844 (toll-free). You can also view the formulary online at www.sanfordhealthplan.com.

- **Exception to formulary.** The Plan will use appropriate pharmacists and Practitioners/Providers to consider exception requests and promptly grant an exception to the drug formulary, including exceptions for anti-psychotic and other mental health drugs, for a Member when the health care Practitioner/Provider prescribing the drug indicates to the Plan that:
  a. the formulary drug causes an adverse reaction in the patient;
  b. the formulary drug is contraindicated for the patient; or
  c. the prescription drug must be dispensed as written to provide maximum medical benefit to the patient.

NOTE: To request an exception to the formulary, please call Pharmacy Management at (855) 263-3547. Requests for an exception to the formulary can also be faxed to (605) 328-6813, or sent via an online fillable form available by logging into your account at www.sanfordhealthplan.com/memberlogin.

If an exception to the formulary is granted, coverage of the non-formulary drug will be provided for the duration of the prescription, including refills. See Pharmaceutical Review Requests and Exception to the Formulary Process in Section 3 for details. Standard requests for an exception to the formulary will be determined within seventy-two (72) hours, urgent requests for an exception to the formulary will be determined within twenty-four (24) hours.

NOTE: Members must generally try formulary medications before an exception for the formulary will be made for non-formulary medication use, unless a Practitioner/Provider determines that use of the formulary drug may cause an adverse reaction to the Member, or be contraindicated for the Member.

- **Drugs that Require Prospective (pre-service) Review and Prior Authorization.** To be covered by Sanford Health Plan, certain medications need a letter of medical necessity or a formulary exception. This can be in the form of written or verbal certification. To request verbal certification, contact Pharmacy Management at (855) 263-3547 | TTY/TDD: (877) 652-1844 (toll-free) between 8 a.m.-5 p.m. Central Time, Monday through Friday. Written certification may be faxed to Pharmacy Management at (605) 328-6813. Please refer to your Formulary for a listing of drugs that require Prospective (Pre-Service) Review and Prior Authorization.

  NOTE: Prior Authorization is required for any prescription filled outside of North Dakota or its contiguous states (SD, MN, MT), unless it is an emergency. This is required by North Dakota Century Code [N.D.C.C. § 50-24.1-37.3(d)]. Contact the Plan for details.

- **There are dispensing limitations.** Prescriptions will be filled for up to a thirty (30) day supply, per copay amount (or less, if prescribed) at one time (unless otherwise approved by the Plan). If you are going on vacation and need an extra supply of medication, you may request a “vacation override”. Please call the Plan for vacation override requests.

Covered medications and supplies

- Drugs and medicines that by Federal law of the United States require a duly-licensed Practitioner’s prescription for their purchase
- Self-Administered Injectable drugs per Plan guidelines (available upon request). Please refer to your Formulary for a list of medications (injectable and high cost medications) that must receive prior certification, and must be obtained by calling (866) 333-9721 (toll-free). If these medications are obtained from a retail pharmacy or physician office without prior certification by Sanford Health Plan’s Pharmacy Management Department, the Member will be responsible for the full cost of the medication.
- Diabetic drugs (See Section 4(a) for Diabetic supplies, equipment, and self-management training benefits)
- Folic acid supplements are covered at 100% (no cost) for women planning to become pregnant or in their childbearing years.
- Generic contraceptives are covered at 100% (no cost). If no generic equivalent exists for a formulary brand-name contraceptive, then that contraceptive is covered at 100% (no cost) per the Affordable Care Act. (See your Formulary for details)
- Other contraceptives, including emergency contraception with generic Plan B, may also covered at 100% (no cost), if obtained with a written prescription (even though by federal or state law, no prescription order is required) from a health care Practitioner and/or Provider; See your Formulary for details.

Not Covered:
- Drugs not listed in the Sanford Health Plan Formulary, or without Prior Authorization or a formulary exception from the Plan
- Replacement of a prescription drug due to loss, damage, or theft
- Outpatient drugs dispensed in a Provider’s office or non-retail pharmacy location
- Drugs otherwise covered under the medical benefits of this plan will not be covered under the prescription drug benefit of this Plan
- Drugs that may be received without charge under a federal, state, or local program
- Drugs for cosmetic purposes, including baldness, removal of facial hair, or pigmenting or anti-pigmenting of the skin
- Refills of any prescription older than one year
- Compound medications with no legend (prescription) medications
- Acne medication for Members over age thirty (30)
- B-12 injection (except for pernicious anemia)
- Drug Efficacy Study Implementation (“DESI”) drugs and drugs identified as identical, related or similar to DESI drugs
- Experimental or Investigational drugs or drug usage not otherwise approved for any indication by the federal Food and Drug Administration or part of an Approved Clinical Trial
- Growth hormone, except when medically indicated and Prior-Approved by the Plan
- Orthomolecular therapy, which including nutrients, vitamins (unless otherwise specified as covered), and food supplements (except to treat PKU or otherwise required to sustain life or amino acid-based elemental oral formulas), nutritional and electrolyte substances
- Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and select diabetic supplies, e.g., insulin syringes, needles, test strips and lancets) that by federal or state law do not require a prescription order
- Any medication that is equivalent to an OTC medication, except for drugs that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, and only when prescribed by a health care Practitioner/Provider
- Drugs and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless the Practitioner certifies off-label use with a letter of medical necessity)
- Anorexiants or weight management drugs (except when Medically Necessary)
- Whole Blood and Blood Components Not Classified as Drugs in the United States Pharmacopoeia
- Medication used to treat infertility
- Unit dose packaging
- Medical Cannabis and its equivalents
- Drugs for sexual performance
- Drugs when indicated or used for erectile dysfunction
Section 4(f) Dental benefits

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

- This Certificate of Coverage, including your application for coverage and any amendments constitutes your entire contract of insurance.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.
- Hospitalization for dental procedures only when a non-dental physical impairment exists, which makes Hospitalization necessary to safeguard the health of the Member. See Section 4(b) for inpatient Hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 3, How you get care, for valuable information about conditions for coverage.
- YOU MUST GET PRE-AUTHORIZATION (CERTIFICATION) OF THESE SERVICES. See the benefit description below.

Benefit Description

NOTE: The following indicated benefits are Outpatient Surgeries, Service, or DME that require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services that Require Prospective Review/Prior Authorization (Certification) in Section 3.)

Dental benefit coverage is as follows:

- Diagnosis and treatment for Craniomandibular disorder are covered subject to Medical Necessity defined by Sanford Health Plan’s Medical coverage guidelines
- Medically Necessary Orthodontics for Members ages 19 and 20
- Coverage for Temporomandibular Joint (TMJ) Dysfunction and/or Temporomandibular Disorder (TMD) is as follows:
  - Services for the Treatment and Diagnosis of TMJ/TMD subject to Medical Necessity defined by Sanford Health Plan’s Medical coverage guidelines
  - Manual therapy and osteopathic or chiropractic manipulation treatment if performed by physical medicine Providers and is Medically Necessary pursuant to Sanford Health Plan’s medical coverage guidelines.
  - TMJ Splints and adjustments if your primary diagnosis is TMJ/TMD
    - Splint limited to one (1) per Member per benefit period. This is a DME that requires Certification.
- Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth, as long as the Member was covered under this Contract during the time of the injury or illness causing the damage. This is an Outpatient Surgery that requires Certification.
  - Care must be received within six (6) months of the occurrence
  - Associated radiology services are included
  - “Injury” does not include injuries to Natural Teeth caused by biting or chewing
  - Coverage applies regardless of whether the services are provided in a Hospital or a dental office

Additional dental services covered for Members ages 19 and 20

Coverage is provided for Emergency, preventive and routine dental care for Members age 19 or 20 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Any EPSDT benefits, including dental services, will terminate at the end of the month in which the Member reaches age twenty-one (21).

NOTE: Dental Services listed below are for Members age 19 or 20 ONLY.

DIAGNOSTIC SERVICES FOR MEMBERS AGE 19 OR 20
- Routine oral evaluations allowed twice during calendar year.
- Bitewing X-rays allowed once annually except when part of a full mouth survey
- Full mouth survey allowed once every 3 years
- Panoramic film allowed once every 3 years
- Intraoral periapical X-rays

PREVENTIVE SERVICES FOR MEMBERS AGE 19 OR 20
- Prophylaxis allowed 4 times during a calendar year
- Topical fluoride applications allowed twice during a calendar year
- Sealants on unfilled, undecayed permanent molars and bicuspids. Benefits are limited to a lifetime maximum of two (2) sealants per tooth
- Space maintainers

RESTORATIVE SERVICES FOR MEMBERS AGE 19 OR 20
- Fillings (pin-retention; limit 2)
- Inlays, onlays and Crowns (not part of a fixed partial Denture). Replacement of lost or defective inlays, onlays or Crowns is allowed
once every 5 years

- Veneers other than cosmetic are allowed once every 5 years

**ENDODONTIC SERVICES FOR MEMBERS AGE 19 OR 20**
- Pulpotomy, pulp capping, root canal therapy, apicoectomy, root amputation, hemisection, bleaching of endodontically treated anterior permanent teeth

**PERIODONTICS FOR MEMBERS AGE 19 OR 20**
- Surgical Periodontic evaluation once for each course of treatment
- Gingivectomy, Gingival Curettage, mucogingival surgery, osseous surgery
- Periodontal scaling and root planing

**PROSTHODONTICS (removable & fixed) FOR MEMBERS AGE 19 OR 20**
- Dentures (complete and partial). Replacement of lost or defective Dentures is allowed once every 5 years
- Tissue conditioning twice per treatment sequence for relining or for new or duplicate Dentures
- Relining of immediate Dentures once during the year after insertion
- Relining of complete and partial Dentures other than in item above, allowed once every 3 years
- Fixed partial Denture. Replacement of lost or defective fixed partial Dentures is allowed once every 5 years.

**ORAL AND MAXILLOFACIAL SURGERY FOR MEMBERS AGE 19 OR 20**
- Simple extractions
- Surgical extractions, including removal of impacted wisdom teeth
- Oral Maxillofacial Surgery including fracture and dislocation treatment, frenectomy and cyst and abscess diagnosis and treatment

**MEDICALLY NECESSARY ORTHODONTICS FOR MEMBERS AGE 19 OR 20**
- Orthodontic care that is directly related to and an integral part of the medical and surgical correction of a functional impairment resulting from a congenital defect anomaly or required because of injury, accident or illness that damages proper alignment of biting or chewing surfaces of upper and lower teeth

**ADJUNCTIVE GENERAL SERVICES FOR MEMBERS AGE 19 OR 20**
- Palliative (Emergency) treatment of dental pain
- Anesthesia services
- Occlusal guard for treatment of Bruxism allowed once every 3 years

**NOTE:** Anesthesia and Hospitalization charges (This is an Outpatient Service that requires Certification.) for dental care are covered for a Member who:
  a. is severely disabled or otherwise suffers from a developmental disability, or
  b. has a high-risk medical condition(s), as determined by a licensed Physician, which places such a person at serious risk.

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**Not Covered:**
- Dental care and treatment (routine or non-routine) for Members ages twenty-one (21) and older, unless otherwise specified as covered in this Certificate of Coverage
- Services determined to be cosmetic by the Plan
- Dental services not specifically listed as Covered by the Certificate of Coverage
Section 4(g) Transportation benefits

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Benefit Description

Member must notify Sanford Health Plan when they need assistance travelling to a medical appointment. The appointment must be for a covered service and with a Participating Practitioner/Provider. Transportation must be Pre-Authorized (Certified).

For Prior-Authorization Transportation Requests, call the Sanford Health Plan Transportation Coordinator toll-free at (800) 236-4907 or TTY/TDD: (877) 652-1844 (toll-free).

If the Member has a privately owned vehicle, family members, or friends that can transport them to medical appointments they are required to use those resources. Recipients are expected to exercise any available free transportation options prior to requesting transportation assistance.

Sanford Health Plan will only provide transportation services if they cannot be obtained free of charge. Transportation requests must be made out of necessity and not for the convenience of the Member.

The following conditions apply:

- A Member may choose to obtain medical services outside the Member’s community; if similar medical services are available within the community, the travel expenses will be the responsibility of the Member.
- If a Member selects a Primary care Provider (PCP) that is outside of the Member’s community when a PCP is available within the Member’s community, the Member is responsible for the transportation to the PCP.
- Sanford Health Plan is required to determine the least expensive, most economical and medically appropriate mode of transportation that meets the medical needs of the Member.
- If free transportation is available, it must be used. Friends, neighbors and family members are expected to provide transportation without reimbursement from Medicaid Expansion.
- No additional travel expenses may be authorized for another driver, attendant or parent unless the referring practitioner, and with prior authorization, determines that person’s presence is necessary for the physical or medical needs of the Member.
- Sanford Health Plan will document each transportation approval, including dates and types of transportation approved, in the Member’s record.
- Sanford Health Plan will cover transportation services to a participating pharmacy to fill a prescription on the date the prescription was written, if it is in conjunction with a medical or dental appointment, or following a discharge from a medical facility.

Non-emergency transportation and travel benefit details

Reimbursement/Payment for transportation services is available to assist Members to obtain necessary medical examination and treatment if those transportation services cannot be obtained free of charge.

Members must call for prior-authorization at least two (2) business days in advance of the scheduled appointment.

In-State Travel
For all in-state travel, reimbursement for meals and lodging may be allowed under specific circumstances and with prior authorization. Every attempt should be made to ensure that the appointment is scheduled at a time that allows for completion of travel in one day.

Out-of-State Travel
Travel is considered Out-of-State if the medical site is located more than fifty (50) miles from the North Dakota border. All out-of-state travel must be for a medical appointment and have prior authorization from Sanford Health Plan.

Reimbursement
Reimbursement for transportation to and from appointments is allowed once every attempt has been made to coordinate the most economical and appropriate means of transportation for the Member. Recipients are responsible for planning transportation to medical appointments in advance; lack of prior planning by a Member does not warrant authorizing a more expensive mode of transportation because no other means is available. All requests for reimbursement must have prior authorization.

To request reimbursement, Members must retain all documentation to support transportation services; the documentation should include
miles travelled, date of service, where the Member was picked up and where they were transported to.

Meals
Reimbursement for meals is allowed only when medical services or transportation arrangements require a Member to be away overnight.

Lodging
Reimbursement for lodging is allowed only when medical services or transportation arrangements require a Member to be away overnight. All requests for reimbursement must have prior authorization.

Not Covered:
- Transportation services in those instances where a Member chooses to obtain medical services outside the Member’s community if similar services are available in the community and the Member does not obtain a referral from a primary physician
- Incidental charges incurred at lodging, including movie charges, phone charges, toiletries, snacks
- Reimbursement for mileage by Members that drive themselves, or family or friends that drive Members, to their appointments
- Any expenses incurred beyond what is authorized
Section 4(h) Out-of-Network and Out-of-State benefits

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

- All benefits are subject to the definitions, limitations and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 3, How you get care, for valuable information about conditions for coverage.
- NOTE: The following services require Certification; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 3.)

This Plan does not pay for health care services received Out-of-Network. Sanford Health Plan would pay for Out-of-Network services only if the services are normally covered but a Participating Provider isn’t able to provide them. Sanford Health Plan must approve of any out-of-network services unless it is an Emergency.

If you choose to receive health care services Out-of-Network without prior-approval from Sanford Health Plan, you will be responsible for all financial charges from that Provider.

Out-of-Network and Out-of-State Services means Covered Services that do not fit the definition of In-Network Coverage set forth in Section 3.

There is no coverage for services received outside of the United States.

Out-of-Network and Out-of-State Services are received:

a. from Non-Participating Providers when appropriate access to a Participating Provider is available;
b. when the Plan has not authorized the referral to a Non-Participating Provider;
c. for a non-Emergency Medical Condition or non-Urgent Care Situation; or
d. from a Participating Practitioner/Provider outside of the Sanford Health Plan Services Area when the Member is traveling outside of the Plan’s service area for the purpose of receiving such services and:
   i. Participating Practitioner/Provider has not recommended the referral; and
   ii. the Plan has not authorized the referral to a Participating Practitioner/Provider outside of the Plan’s Service Area.

Members must use the Plan’s Network Participating Providers. Members who are outside the Service Area must follow Plan instructions on how to access the Participating Provider Network. If a Member chooses to go to a Non-Participating Provider when access is available, the Member will be responsible for all financial charges from that Provider.

NOTE: Out-of-Network and Out-of-State Services Coverage will only be provided in the United States when traveling outside the Plan’s Service Area. Out-of-Network Coverage Prior-Authorization rules apply, unless for care that is otherwise not required to receive prior authorization and is available by a Participating Provider. For more information, see Section 3.
Section 5. Limited and Non-Covered Services

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

General Exclusions

1. Health Care Services, including pharmaceutical and outpatient drug benefits, provided prior to the effective date of the Member’s coverage with the Plan, or subsequent to the date coverage is terminated by the State of North Dakota.

2. Health Care Services performed by any Provider who is a Member of the Member’s immediate family, including any person normally residing in the Member’s home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only Participating Provider in the area, the Member may go to a Non-Participating Provider and receive in-Network coverage (Section 3, Appropriate Access). If the immediate family member is not the only Participating Provider in the area, the Member must go to another Participating Provider in order to receive coverage at the in-Network level.

3. Health Care Services covered by any governmental agency/unit for military service-related injuries/diseases, unless applicable law requires the Plan to provide primary coverage for the same.

4. Health Care Services for injury or disease due to voluntary participation in a riot, unless source of injury is a result of domestic violence or a medical condition.

5. Health Care Services for sickness or injury sustained in the commission of a felony, unless source of injury is a result of domestic violence or a medical condition.

6. Health Care Services that the Plan determines are not Medically Necessary.

7. Experimental and Investigational Services not part of an Approved Clinical Trial.

8. Services that are not Health Care Services.

9. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner/Provider or electronic consultations.

10. Services not performed in the most cost-efficient setting appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate.

11. Charges for duplicating and obtaining medical records from Non-Participating Providers unless requested by the Plan.

12. Charges for sales tax, mailing, interest and delivery.

13. Charges for services determined to be duplicate services by the Plan Chief Medical Officer or designee.

14. Charges that exceed the Maximum Allowed Amount for Non-Participating Providers.

15. Services to assist in activities of daily living.

16. Alternative treatment therapies including, but not limited to: acupuncture, acupressure, biofeedback, chelation therapy, massage therapy unless covered per Plan guidelines under WHCRA for mastectomy/lymphedema treatment, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, sleep therapy (except for treatment of obstructive apnea), or therapeutic touch.

17. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management.

18. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics.

19. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home.

20. Any services or supplies for the treatment of obesity that do not meet the Plan’s medical necessity coverage guidelines, including but not limited to: dietary regimen (except as related to covered nutritional counseling), nutritional supplements, or food supplements, and/or weight loss or exercise programs.

21. Developmental Delay Care including services or supplies, regardless of where or by whom they are provided which:
   a. Are less than two standard deviations from the norm as defined by standardized, validated developmental screening tests, such as the Denver Developmental Screening Test; or
   b. Are educational in nature; vocational and job rehabilitation, recreational therapy.

22. Special education, including lessons in sign language to instruct a Member, whose ability to speak has been lost or impaired, to function without that ability.

23. Panniculectomy or sequela (i.e. anemia, breast reduction, hernia repair, gallbladder removal) as result of gastric bypass surgery that do not meet criteria for medical necessity.

24. Cosmetic Services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member’s appearance and/or not medically necessary, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services.


26. Food items for medical nutrition therapy (except as specifically allowed in the Covered Benefits Section of this Certificate of Coverage).

27. Any fraudulently billed charges or services received under fraudulent circumstances.

28. Genetic testing, unless prior authorized by the Plan. Exclusion does not include genetic testing required by evidence-based services that have a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force, per Plan guidelines. Prior authorization is required for the Plan to cover any genetic test.

29. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events. Participating Providers are not permitted to bill Members for services related to such events.
30. Autopsies, unless the autopsy is at the request of the Plan in order to settle a dispute concerning provision or payment of benefits. The autopsy will be at the Plan’s expense.

31. Iatrogenic condition illness or injury as a result of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error. Charges related to iatrogenic illness or injury are not the responsibility of the Member.

32. Health services received outside of the United States.

33. Room and board charges for Members ages 21 and over at a Residential Treatment Facility

34. Inpatient treatment for Members ages 21 and over at a Facility that is an Institution for Mental Diseases (IMD)

**Special situations affecting coverage**

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

a. Complete or partial destruction of the Plan’s facilities;

b. Declared or undeclared acts of War or Terrorism;

c. Riot;

d. Civil insurrection;

e. Major disaster or unforeseen natural events which materially interfere with the ability to provide Health Care Services;

f. Disability of a significant portion of the Participating Providers;

g. Epidemic or the inability to obtain vaccines or medicines due to circumstances beyond the control of the Plan; or

h. A labor dispute not involving the Plan Participating Providers, the Plan will use its best efforts to arrange for the provision of Covered Services within the limitations of available facilities and personnel. If provision or approval of Covered Services under this Contract is delayed due to a labor dispute involving the Plan Participating Providers, Non-Emergency Care may be deferred until after resolution of the labor dispute.

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

**Services covered by other payors**

The following are excluded from coverage:

1. Health services for which other coverage is either (1) required by federal, state or local law to be purchased or provided through other arrangements or (2) has been made available to and was purchased by the Covered Person. Examples include coverage required by workers’ compensation, no-fault auto insurance, medical payments coverage, or similar legislation. The Plan is not issued in lieu of nor does it affect any requirements for coverage by Workers’ Compensation. For injuries or sickness which are job, employment or work related, under which benefits are paid by under any Workers’ Compensation or Occupational Disease Act or Law, this Plan contains a limitation which states that such health services are excluded from coverage by the Plan. However, if benefits are paid by the Plan and it is determined that the Member is eligible to receive Workers’ Compensation for the same incident; the Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Member agrees to reimburse the Plan the full amount, which the Plan has paid for Health Care Services when entering into a settlement or compromise agreement relating to compensation for the Health Care Services covered by Workers’ Compensation, or as part of any Workers’ Compensation Award. The Plan reserves its right to recover against Member even though:

a. The Workers’ Compensation benefits are in dispute or are made by means of settlement or compromise; or

b. No final determination is made that the injury or sickness was sustained in the course of or resulted from employment;

c. The amount of Workers’ Compensation for medical or health care is not agreed upon or defined by Member or the Workers’ Compensation carrier, or

d. The medical or health care benefits are specifically excluded from the Workers’ Compensation settlement or compromise.

Member will not enter into a compromise or hold harmless agreement relating to any work related claims paid by the Plan, whether or not such claims are disputed by the Workers’ Compensation insurer, without the express written agreement of the Plan.

2. Health Care Services received directly from Providers employed by or directly under contract with the Member’s employer, mutual benefit association, labor union, trust, or any similar person or group.

3. Health Care Services for injury or sickness for which there is other non-group insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess, or contingent to the Plan. If the benefits subject to this provision are paid for or provided by the Plan, the Plan may exercise its Rights of Subrogation.

4. Health Care Services for conditions that under the laws of This State must be provided in a governmental institution.

5. Health Care Services covered by any other governmental health benefit program such as Medicare, Traditional (FFS) Medicaid, ESRD and/or TRICARE (active-duty), unless applicable law requires the Plan to provide primary coverage for the same.

**Services and payments that are the responsibility of Member**

1. Out-of-pocket costs, including Copays, are the responsibility of the Member, in accordance with the Member’s Summary of Benefits and Coverage (SBC). Additionally, the Member is responsible to a Provider for payment for Non-Covered Services;

2. Finance charges, late fees, charges for missed appointments and other administrative charges; and

3. Services for which a Member is either legally, or as customary practice, required to pay in the absence of a group health plan or other coverage arrangement.
Section 6. How services are paid for by the Plan

Reimbursement of Charges by Participating Providers

When you see Participating Providers, receive services at Participating Providers and facilities, or obtain your prescription drugs at Network pharmacies, you will not have to file claims. You will need to present your identification card and pay your Copay. When a Member receives Covered Services from a Participating Provider, the Plan will pay the Participating Provider directly, and the Member will not have to submit claims for payment. In this case, at the time of service the Member’s only payment responsibility is to pay the Participating Provider any Copay amount that is required for that service. Participating Providers agree to accept either Sanford Health Plan’s payment arrangements or its negotiated contract amounts.

Time Limits. Participating Providers must file claims to the Plan within three hundred and sixty-five (365) days after the date that the cost was incurred. If Member fails to show his/her Plan ID card at the time of service, then Member may be responsible for payment of claim after Practitioner/Provider’s timely filing period of three hundred and sixty-five (365) days has expired.

In any event, the claim must be submitted to the Plan no later than three hundred and sixty-five (365) days after the date that the cost was incurred, unless the claimant was legally incapacitated.

Reimbursement of Charges by Non-Participating Providers

Sanford Health Plan does not have contractual relationships with Non-Participating Practitioners/Providers and they may not accept the Plan’s payment arrangements. In addition to any Copay amount required for that service, Members are responsible for any difference between the amount charged and the Plan’s payment for covered services. Non-Participating Practitioners/Providers are reimbursed the Maximum Allowed Amount, which is the lesser of:

(a) the amount charged for a covered service or supply; or

(b) inside Sanford Health Plan’s service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or

(c) outside of Sanford Health Plan’s service area, using current publicly available data adjusted for geographical differences where applicable:
   i. Fees typically reimbursed to providers for same or similar professionals; or
   ii. Costs for facilities providing the same or similar services, plus a margin factor.

You may need to file a claim when you receive services from Non-Participating Practitioners and/or Providers. Sometimes these Practitioners/Providers submit a claim to us directly. Check with the Practitioner/Provider to make sure they are submitting the claim. You are responsible for making sure claim is submitted to the Plan within three hundred and sixty-five (365) days after the date that the cost was incurred. If you, or the Non-Participating Practitioner/Provider, does not file the claim within three hundred and sixty-five (365) days after the date that the cost was incurred you may be responsible for payment of the claim.

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

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

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

Health Care Services Received Outside of the United States

There is no coverage for health care services for medical treatment received outside the United States.

Time Limits: Claims must be submitted to the Plan within three hundred and sixty-five (365) days after the date that the cost was incurred. If you, or the Non-Participating Practitioner/Provider, file the claim after the three hundred and sixty-five (365) timely filing limit has expired, you may be responsible for payment of the claim.

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

Payment to Non-Participating Providers

When a Member receives Covered Services from a Non-Participating Provider and payment is to be made according to Plan guidelines, the Plan will arrange for direct payment to the Non-Participating Provider, per Plan guidelines. Plan guidelines include but are not limited to the reduction in payment by the Plan.

Timeframe for Payment of Claims

The payment for Covered Services will be made within fifteen (15) days of when the Plan receives a complete written claim with all required supporting information. Per federal and state regulations, Members will not be reimbursed directly by the Plan for costs paid directly

Sanford Health Plan
to Providers.
When a Member receives Covered Services from a Non-Participating Provider and payment is to be made according to Plan guidelines, the Plan will arrange for direct payment to the Non-Participating Provider, per Plan policy. If the Provider refuses direct payment, the Plan reserves the right to make alternative arrangements to payment of the Maximum Allowed Amount of the services, in accordance with the terms of this Certificate of Coverage. The Member will be responsible for any expenses that exceed the Maximum Allowed Amount, as well as any Copay required for the Covered Service.

When we need additional information

Please reply promptly when we ask for additional information. We may delay processing or deny your claim if you do not respond.
Section 7. Problem Resolution

Member Appeal and Complaint Procedures
Sanford Health Plan makes decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care.

A Member, health care Practitioner/Provider with knowledge of the Member’s medical condition, Authorized Representative of the Member, legal representative of a deceased Member’s estate, and/or an attorney may request a review of any Non-Covered Service and/or Adverse Benefit Determination by Sanford Health Plan.

Members must give written consent for health care Practitioners/Providers to file grievances (Complaints), appeals, and request fair hearings on a Member’s behalf. With written consent, health care Practitioners/Providers may file grievances (Complaints), appeals, and request fair hearings on a Member’s behalf. No punitive action will be taken against a health care Practitioner/Provider who requests an expedited resolution or supports a Member’s Appeal.

Definitions

Adverse Benefit Determination: Means the:
1. Denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for Medical Necessity, appropriateness, setting, or effectiveness of a covered benefit;
2. Reduction, suspension, or termination of a previously authorized service;
3. Denial, in whole or in part, of payment for a service;
4. Failure to provide services in a timely manner
5. Failure of the Plan to act within the timeframes provided in 42 CFR § 438.408(b)(1) and (2) regarding the standard resolution of Grievances and Appeals;
6. Denial of an Member’s request to exercise his or her right, under 42 CFR § 438.52(b)(2)(ii), to obtain services outside the network; or
7. Denial of a Member’s request to dispute a financial liability, including cost sharing, copayments, and other Member financial liabilities.

Appeal: Means a request for a review of an Adverse Benefit Determination, including a Non-Covered Service Determination, made by Sanford Health Plan.

Complaint (Grievance): An oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination.

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

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

Non-Covered Service Determination: Means a review of Certificate of Coverage language, contractual terms, and administrative policies related to services covered under this Plan, and determinations made do not involve Medical Necessity. A Non-Covered Service Determination is eligible for internal appeal as an Adverse Benefit Determination. Non-Covered Service Determinations are not eligible for external review through State Fair Hearing requests.

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

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

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

In determining whether a request is “Urgent,” the Plan shall apply the judgment of a Prudent Layperson as defined in Section 10. When a Practitioner with knowledge of the Member’s medical condition determines a request to be an Urgent Care Situation, the Plan shall treat the prospective review as an Urgent Care Request.

Complaint (Grievance) Procedures
A Member; health care Practitioner/Provider with the written consent of the Member and knowledge of the Member’s medical condition; Authorized Representative of the Member; legal representative of a deceased Member’s estate; and/or an attorney may file a Complaint with the Plan’s Customer Service Department by telephone, electronic means, or in writing. Complaints may be filed orally or in writing.

Customer Service will make every effort to investigate and resolve all Complaints. Customer Service can be reached toll-free at (855) 305-5060 | TTY/TDD: (877) 652-1844 (toll-free). For more information on help provided by the Plan, see Special Communication & Language Access Services in the Introduction section of this Certificate of Coverage.

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Complaints (Grievances)

A complainant may orally submit a Complaint to the Customer Service Department. If the oral Complaint is not resolved to the complainant’s satisfaction within ten (10) calendar days of receipt of the Complaint, the Plan will provide a Complaint form to the complainant, which may be completed and returned to the Customer Service Department for consideration. Upon request, Customer Service will provide assistance in submitting the Complaint form. A written complaint form is not required in order for a Member to file a complaint with the Plan.

A complainant can seek further review of a Complaint not resolved by phone by optionally choosing to submit a written Complaint form. A Member, or his/her Authorized Representative may send the completed Complaint form, including comments, documents, records and other information relating to the Complaint, the reasons they believe they are entitled to benefits and any other supporting documents to:

Sanford Health Plan
Customer Service Department
PO Box 91110
Sioux Falls, SD 57109-1110
or Fax: (605) 328-6812

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

Complaints based on discrimination must be sent to the attention of the Civil Rights Coordinator.

Complaint Investigations

The Plan will acknowledge receipt of each Complaint. Upon request and at no charge, the complainant will be given reasonable access to and copies of all documents, records and other information relevant to the Complaint. Customer Service will investigate and review all Complaints and notify the complainant of Sanford Health Plan’s decision in accordance with the following timelines:

1. A decision and written notification on the Complaint will be made to the complainant, his or her Practitioners/Providers involved in the provision of the service within ninety (90) calendar days from the date the Plan receives your request.

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

3. Any complaints related to the quality of care received are subject to practitioner review. If the complaint is related to an Urgent clinical matter, it will be handled in an expedited manner and a response will be provided within seventy-two (72) hours.

Unresolved Appeals

If an Appeal is not resolved to the Member’s satisfaction, the Member, and/or his/her Authorized Representative, has the right to file an appeal. Appeal Rights may be requested by calling Customer Service toll-free at (855) 305-5060 | TTY/TDD: (877) 652-1844, 8:00 am to 5:00 pm, Central Time, Monday through Friday. To contact Sanford Health Plan in a language other than English, call (800) 892-0625 (toll-free). Language assistance services are free of charge.

All notifications described in Section 7 will comply with applicable law. A complete description of your Appeal rights and the Appeal process will be included in written responses from the Plan.

### Appeal Procedures

#### Types of Appeals

1. A **Prospective (Pre-Service) Appeal** is a request to change an Adverse Benefit Determination, in whole or in part, in advance of the Member obtaining care or services.

2. A **Retrospective (Post-Service) Appeal** is a request to change an Adverse Benefit Determination for care or services already received by the Member.

3. An **Expedited Appeal (Urgent Care Request)** is a request to change a previous Adverse Benefit Determination made by Sanford Health Plan. If the Member’s situation meets the definition of Urgent, a determination will be made within 72 hours.

#### Continued Coverage for Concurrent Care

If the determination being Appealed is to terminate, suspend, or reduce a previously authorized course of treatment; or the services were ordered by an authorized Provider and the original period covered by the original authorization has not expired and the Member wants disputed services to continue during the Appeal process; then the Member, Member’s Authorized Representative (as designated in writing by the Member), and/or the Member’s Practitioner/Provider shall file an Appeal either orally or in writing on or before the later of the following:

1. Within ten (10) calendar days of the Plan mailing the notice of Adverse Benefit Determination; or

2. The intended effective date of the Plan’s determination.

If the final determination is adverse to the Member, Sanford Health Plan has the right to recover the cost of services furnished while an Appeal is pending. The Member may be liable for the cost of the continued benefits if benefits were requested to continue during the Appeal process.

#### Audit Trails

Audit trails for Complaints, Adverse Benefit Determinations and Appeals are provided by the Plan’s Information System and an Access database, which includes documentation of the Complaints, Adverse Benefit Determination and/or Appeals by date, service, procedure,
The written decision for Internal Appeal is based on the Adverse Benefit Determination. The Plan will state the reason for the determination and provide the Member with the right to request a State Fair Hearing and how to request a State Fair Hearing. The written decision for Internal Appeals will contain the following information:

1. The results and date of the Appeal Determination;
2. The specific reason for the Adverse Benefit Determination in easily understandable language;
3. The titles and qualifications, including specialty, of the person or persons participating in the first level review process (Reviewer names are available upon request);
4. Reference to the evidence, benefit provision, guideline, and/or protocol used as the basis for the decision and notification that the Member on request can have a copy of the actual benefit provisions, guidelines, and protocols free of charge;
5. If the Adverse Benefit Determination is regarding coverage for a mental health and/or substance use disorder, a statement notifying Members of their opportunity to request treatment and diagnosis code information free of charge;
6. Notification the Member can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Member’s appeal request;
7. Statement of the reviewer’s understanding of the Member’s Appeal;
8. The Reviewer’s decision in clear terms, and the contract basis, or medical rationale, in sufficient detail for the Member to respond further;
9. If the Adverse Benefit Determination is based on medical necessity, notification and instructions on how the Practitioner/Provider can contact the Physician or appropriate practitioner to discuss the determination;
10. If the Adverse Benefit Determination is based on medical necessity or an Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the Plan to the Member’s medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
11. If applicable, instructions for requesting:
   a. A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; or
   b. The written statement of the scientific or clinical rationale for the determination;
12. Notice of the right to initiate the External Review process for Adverse Benefit Determinations based on medical necessity. Refer to “Independent, External Review of Final Determinations” in this Section for details on this process. Final Adverse Benefit Determination letters from the Plan will contain information on the circumstances under which Appeals are eligible for External Review and information on how the Member can seek further information about these rights; and
13. If the Adverse Benefit Determination is completely overturned, the determination notice will state the decision and the date.
14. **For Adverse Benefit Determinations of Prospective (Pre-service) or Retrospective (Post-service) Reviews**: a statement indicating:
   a. The written procedures governing the standard internal review, including any required timeframe for the review; and
   b. For decisions not wholly in the Member’s favor, the right to request a State Fair Hearing and how to request a State Fair Hearing within one hundred and twenty (120) days;
   c. If the timeline is extended for an appeal and it is not at the request of the Member, the Plan will make reasonable efforts to give the Member prompt oral notice of the delay and give the Member written notice within 2 calendar days of the reason for the decision to
extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with the Plan’s decision to extend the decision time.

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

If a Member, health care Practitioner/Provider with knowledge of the Member’s medical condition, Authorized Representative of the Member, legal representative of a deceased Member’s estate, and/or an attorney or a Member’s authorized representative (as designated in writing by the Member) files an Appeal for an Adverse Benefit Determination, the following Appeal Rights apply:

1. The Member shall have the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. Members, Authorized Representatives, and/or Practitioners/Providers have the right to present evidence in person.
2. The Member shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by, or at the direction of, Sanford Health Plan in connection with the claim; and such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give the Member a reasonable opportunity to respond prior to that date.
3. Confirm with the Member whether additional information will be provided for Appeal review. The Plan will document if additional information is provided or no new information is provided for Appeal review.
4. Before Sanford Health Plan can issue a final Adverse Benefit Determination based on a new or additional rationale, the Member will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination is required to be provided and give the Member a reasonable opportunity to respond prior to the date.
5. The Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Member’s initial request.
6. For Mental Health and/or Substance Use Disorder (MH/SUD) Adverse Benefit Determinations, if information on any medical necessity criteria is requested, documents will be provided for both MH/SUD and medical/surgical benefits within 30 calendar days of a Member/Member's Authorized Representative/Provider's request. This information will include documentation of processes, strategies, evidentiary standards and other factors used by the Plan, in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
7. The review shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
8. Full and thorough investigation of the substance of the Appeal, including any aspects of clinical care involved, will be coordinated by the appropriate Plan personnel.
9. The Plan will document the substance of the Appeal, including but not limited to, the Member’s reason for appealing the previous decision and additional clinical or other information provided with the Appeal request. The Plan will also document any actions taken, including but not limited to, previous denial or appeal history and follow-up activities associated with the denial and conducted before the current Appeal.
10. The review shall not afford deference to the initial Adverse Benefit Determination; and shall be conducted by a named Plan representative, who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal nor the subordinate of such individual.
11. In deciding an Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Plan shall consult with a health care professional (same-or-similar specialist) who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care Practitioner/Provider engaged for purposes of a consultation under this paragraph shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of any such individual.
12. The Plan shall identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Member’s Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit request determination.
13. In order to ensure the independence and impartiality of the persons involved in making claims determinations and Appeals decisions, all decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.
14. The attending Practitioner/Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Appeal within three (3) business days of the Plan’s receipt of the Appeal.
15. Sanford Health Plan will provide notice of any Adverse Benefit Determination in a manner consistent with applicable federal regulations.

### Standard (Non-Urgent) Appeal Decision Notification Timeframes

For Prospective (Pre-service) Appeals: the Plan will notify the Member or their Authorized Representative and any Practitioners/Providers involved in the Appeal of its decision in writing, or electronically, within thirty (30) calendar days of receipt of the Appeal. Member notification of the Appeal response will be logged for reference. Members will be notified by the Plan upon receipt of the Appeal and upon the Plan’s decision on the Appeal.

For Retrospective (Post-service) Appeals: the Plan will notify the Member or their Authorized Representative and any Practitioners/Providers involved in the Appeal of its decision in writing, or electronically, within thirty (30) calendar days of receipt of the
Appeal. Member notification of the Appeal response will be logged for reference. Members will be notified by the Plan upon receipt of the Appeal and upon the Plan’s decision on the Appeal.

For Appeals Based on Discrimination: the Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the Appeal in writing within thirty (30) calendar days of receipt of the Appeal.

### Expedited (Urgent) Appeal Procedure

The procedures in this subsection are used for an **Expedited (Urgent) Appeal**, which is when the Member’s condition is urgent or emergent. An **Expedited Appeal** procedure is used when the condition is an Urgent Care Situation, as defined previously in this Certificate of Coverage. An expedited review involving Urgent Care Requests for Adverse Benefit Determinations of Pre-service or Concurrent claims will be utilized if the Member or Practitioner/Provider acting on behalf of the Member believe(s) that an expedited determination is warranted. All of the procedures of a standard review described above apply. In addition, for an Expedited Appeal, the request for an expedited review may be submitted. This can be done orally or in writing and the Plan will accept all necessary information by telephone or electronically. In such situations, the Practitioner who made the initial Adverse Benefit Determination may review the Appeal and overturn the previous decision.

**Timeframes**

The determination will be made and provided to the Member and those Practitioners/Providers involved in the Appeal via oral notification by the Utilization Management Department as expeditiously as the Member’s medical condition requires but no later than seventy-two (72) hours of receipt of the request. Sanford Health Plan will notify you orally by telephone or in writing by facsimile or via other expedient means.

The Member and those Practitioners/Providers involved in the Appeal will receive written notification within twenty-four (24) hours of the oral notification. If your request for an Expedited Appeal review is denied, it will be handled in the same manner as a Non-Urgent Pre-Service or a Non-Urgent Post-Service Appeal, depending upon the type of denial being appealed. The standard timeframe for non-Urgent Appeal determinations is thirty (30) calendar days, with a possible 14-calendar day extension for resolving the appeal and providing notice of the appeal resolution. Members may file a complaint (grievance) if they disagree with the decision to extend the time allowed for issuing the decision.

If the expedited review is a Concurrent Review determination, the service will be continued without liability to the Member until the Member or the representative has been notified of the determination. See **Continued Coverage for Concurrent Care** previously mentioned in this Section for Member responsibilities if Member wishes care to continue during the Appeal process. If the final decision is not in the Member’s favor, the Member may be responsible for payment of services received while the appeal was being reviewed.

### State Fair Hearing External Review of Final Adverse Benefit Determinations (Denial)

The Plan will follow the procedure for providing independent, external review of final determinations in accordance with guidelines set forth by North Dakota Department of Human Services Medical Services Division. Accordingly, upon exhaustion of the Plan’s internal appeals process, a Member may pursue an external review of a final Adverse Benefit Determination by requesting a State Fair Hearing with the North Dakota Department of Human Services.

**NOTE:** Non-Covered Service Determinations, e.g. denials that do not involve medical/clinical review, are not eligible for a State Fair Hearing. The Plan’s decision on Non-Covered Service Determinations is final and binding.

### State Fair Hearing Request Procedures

**External Review Requests**

Members may file a request for a State Fair Hearing with the Department of Human Services Medical Services Division at:

**Appeals Supervisor, Legal Advisory Unit**

N.D. Department of Human Services  
600 E Boulevard Avenue, Dept. 325  
Bismarck, ND 58505-0250  
Email: dhslau@nd.gov  
Phone: (701) 328-2311 | (800) 472-2622 (toll-free)  
ND Relay TTY: (800) 366-6888

**For Adverse Benefit Determinations of Prospective (Pre-service) or Retrospective (Post-service) Appeal Reviews, not wholly in the Member's favor, the Plan will provide:**

1. The right to request a State Fair Hearing within one hundred and twenty (120) days from the date of the written Adverse Benefit Determination notice with the following conditions:
   a. The Member has completed the Internal Appeal process through Sanford Health Plan with the Adverse Benefit Determination being upheld, or
   b. Sanford Health Plan has failed to adhere to the notice and timing requirements of the Internal Appeal process which then the Member is deemed to have exhausted the Plan’s appeal process;
2. How to request a State Fair Hearing;
3. The right to continue to receive benefits pending a hearing with the following conditions:
   a. The Appeal is filed in a timely manner;
   b. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
   c. The services were ordered by an authorized Provider;
   d. The period covered by the original authorization has not expired; and
e. The Member requests the extension of benefits; and

4. How to request the continuation of benefits. If the Plan continues or reinstates the Member’s benefits, the benefits will be continued until one of the following:
   a. The Member withdraws the Appeal; or
   b. Ten (10) days pass after the Plan mails its Notice of Adverse Benefit Determination (unless the Member has requested continuation of benefits pending a State Fair Hearing decision); or
   c. A State Fair Hearing officer issues a hearing decision adverse to the Member; or
   d. The time period or service limit of a previously authorized service has been met; and

5. If the Plan’s action is upheld in a hearing, the Member may be liable for the cost of the continued benefits;

6. If the Plan or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, then the Plan will authorize or provide the disputed services promptly, and as expeditiously as the Member’s health condition requires; and

7. If the Plan or the State Fair Hearing officer reverses a decision to deny authorization of services and the Member received the disputed services while the Appeal was pending, then the Plan will pay for the disputed services.

**NOTE:** All notifications and procedures described in Section 7, in addition to those related to both Covered Service and Adverse Benefit Determinations in Section 3, will comply with applicable law. Should a conflict exist between Plan procedures and federal/state regulations, federal and/or state regulations shall control.

A complete description of your Complaint (Grievance) and Appeal Rights and the Appeal process will be included in determination responses and decisions made by Sanford Health Plan. Additionally, an overview of your Complaint (Grievance) and Appeal Rights, along with an *Appeal Filing Form*, is included in all Explanation of Benefits (EOBs) generated by Sanford Health Plan.
Section 8. Coordination of Benefits (COB)

When you have other coverage

Pursuant to federal and state laws that govern the Medicaid Expansion Program, the Plan is the payor of last resort which means that Sanford Health Plan has the right to deny the payment of benefits if the Member’s Covered Services are covered under another health insurance or medical expense policy.

Having other insurance does not change whether or not you can have Medicaid Expansion coverage, unless you have Medicare or traditional Medicaid coverage. You must report any other insurance so that the Plan stays the payor of last resort.

Medicaid Providers cannot refuse to see you because you also have private health insurance. If Providers say they will see you as a Medicaid patient, they must tell your private health insurance company as well.

Effect of COB on the benefits of this plan

1. Sanford Health Plan is entitled to:
   a. Determine whether and to what extent a Member has indemnity coverage or other health benefit coverage for Covered Services; and
   b. Establish the priorities for determining primary responsibility among the payers including Sanford Health Plan, obligated to provide health care services or indemnity benefits; and
   c. Require a Member or Provider to file a claim with the primary payer before it determines the amount of Sanford Health Plan payment obligation, if any; and recover from the Member or Provider, as applicable, the expense of Covered Services rendered to a Member to the extent that such services are covered or indemnified by any other payer; and
   d. Recover from the Member or Provider, as applicable, the expense of services rendered to a Member which are subsequently determined to be Non-Covered Services and were incorrectly provided because of the Member’s error.

2. Nothing in this subsection shall be construed to require Sanford Health Plan to make payment until it determines whether it is the primary payer or the secondary payer and what benefits are payable by the primary payer.

Right to receive and release needed information

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

Right of recovery

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

Coordination of benefits with other plans

Generally, Medicaid is the payor of last resort for insured claims. Before this Plan pays, any group or individual coverage will pay primary. Medicaid is always the secondary payor on claims; however, if the Member also has TRICARE, TRICARE pays primary to this Plan and Medicaid Expansion pays tertiary (last). When a Member is covered under both this Plan (Medicaid Expansion) and TRICARE, this Plan will pay secondary to TRICARE to the extent required by federal law.

Coordination of benefits with TRICARE

TRICARE is the primary payer if the TRICARE beneficiary is enrolled in, or covered by, Medicaid Expansion (this Plan) to the extent that the service provided is also covered under this Plan.

1. When a TRICARE beneficiary is covered under this Plan, and also entitled to Medicaid Expansion, TRICARE will be the primary payer, absent other coverage, and this Plan will be tertiary (last).

2. TRICARE-eligible Members receive primary coverage under this Plan’s provisions in the same manner, and to the same extent, as similarly situated Members who are not TRICARE eligible.

Sanford Health Plan does not:

1. Provide financial or other incentives for a TRICARE-eligible Member 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 Member of the opportunity receive care as a beneficiary under Medicaid Expansion.
Section 9. Subrogation and Right of Reimbursement

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

If a Member has received or receives a recovery from the third party, the Health Plan has a right to reduce, or be reimbursed for, benefits it has provided and to be provided to the Member. This is called “Reimbursement” and this part of this Contract 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 8 and 9.

A Member will give this Plan the information it asks for about other plans and their payment for Covered Services. 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 Certificate of Coverage covers such situations.

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

Plan’s Rights of Subrogation

In the event of any payments for benefits provided to a Member under this Contract (“Certificate of Coverage”), the Plan, to the extent of such payment, shall be subrogated to all rights of recovery from such Member, his or her parents, heirs, guardians, executors, or other representatives may have against any person or organization. These subrogation and reimbursement rights also include the right to recover from uninsured motorist insurance, underinsured motorist insurance, no-fault insurance, automobile medical payments coverage, premises medical expense coverage, and workers’ compensation insurance or substitute coverage.

The Plan shall be entitled to receive from any such recovery an amount up to the Maximum Allowed Amount for the services provided by the Plan. In providing benefits to a Member, the Plan may obtain discounts from its health care Providers, compensate Providers on a capitated basis or enter into other arrangements under which it pays to another less than the Maximum Allowed Amount 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 Maximum Allowed Amount of the benefits it provides on account of such illness or injury, even if the Maximum Allowed Amount exceeds 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 Maximum Allowed Amount Charge for the Health Care Services provided to the Member. The Plan may give notice of that lien to any party who may have contributed to the loss.

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

Plan’s Right to Reduction and Reimbursement

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

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

The Plan shall have a lien on all funds received by the Member, his or her parents, heirs, guardians, executors, or other representatives up to the Maximum Allowed Amount 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 his or her 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 Maximum Allowed Amount for services subject to this section and any legal costs incurred by the Plan to enforce its rights under this Section.

4. The Plan shall have no obligation whatsoever to pay medical benefits for a Member if a Member 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.

5. 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.

<table>
<thead>
<tr>
<th>Payment in Error</th>
</tr>
</thead>
<tbody>
<tr>
<td>If for any reason we make payment under this Certificate of Coverage in error, we may recover the amount we paid.</td>
</tr>
</tbody>
</table>
Section 10. Defined terms in this Certificate of Coverage

| Ambulatory Surgical Center | A lawfully operated, public or private establishment that:  
|                           | a. Has an organized staff of Providers;  
|                           | b. Has permanent facilities that are equipped and operated mostly for performing surgery;  
|                           | c. Has continuous Provider’s services and Nursing Services when a Member is in the Facility; and  
|                           | d. Does not have services for an overnight stay. |
| Approved Clinical Trial    | A phase I, II, III, or IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:  
|                           | a. A federally funded or approved trial;  
|                           | b. A clinical trial conducted under an FDA investigational new drug application; or  
|                           | c. A drug trial that is exempt from the requirement of an FDA investigational new drug application. |
| Authorized Representative  | A person to whom a covered person has given express written consent to represent the Member, a person authorized by law to provide substituted consent for a Member, a legal representative of a deceased Member’s estate, a family member of the Member or the Member’s treating health care professional if the Member is unable to provide consent, or a health care professional if the Member’s Plan requires that a request for a benefit under the Plan be initiated by the health care professional. For any Urgent Care Request, the term includes a health care professional with knowledge of the Member’s medical condition. |
| Avoidable Hospital Conditions | Conditions, which could reasonably have been prevented through application of evidence-based guidelines. These conditions are not present on admission, but present during the course of the stay. Participating Providers are not permitted to bill the Plan or Members for services related to Avoidable Hospital Conditions. |
| Billed Charge              | The amount a Provider bills for all services and supplies, whether or not the services and supplies are covered under this Certificate of Coverage. |
| Calendar Year              | A period of one year which starts on January 1st and ends December 31st. |
| Case Management            | A coordinated set of activities conducted for individual patient management of chronic, serious, complicated, protracted, and/or other health conditions. |
| Certification              | Certification is a determination by the Plan that a prior request for a benefit has been reviewed and, based on the information provided, satisfies the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness. Also known as Authorization. |
| Concurrent Review          | Concurrent Review is Utilization Review for an extension of previously approved, ongoing course of treatment over a period of time or number of treatments typically associated with Hospital inpatient care including care received at a Residential Treatment Facility, and ongoing outpatient services, including ongoing ambulatory care. |
| [This] Contract or [The] Contract | This Certificate of Coverage, which is a statement of the essential features and services, given to the Subscriber by the Plan, which constitutes your entire Contract of insurance. |
| Copay                      | An amount that a Member must pay in order to receive a Covered Service that is not fully pre-paid. |
| Coordinated Services Program (CSP) | The Coordinated Services Program (CSP) ensures that a Member is restricted into a pharmacy and a Primary Care Physician, when the Member meets the identified criteria, pursuant to 42 CFR §431.54. The CSP coordinates care and ensures that Members selected for enrollment in the CSP use services appropriately and in accordance with Plan rules and policies. |
| Covered Services           | Those Health Care Services to which a Member is entitled under the terms of this Contract. |

Creditable Coverage

Benefits or coverage provided under:

- A group health benefit plan (as such term is defined under North Dakota law);
- A health benefit plan (as defined under state and federal laws);
- Medicare or Medicaid;
- Civilian health and medical program for uniformed services;
- A health plan offered under 5 U.S.C. 89;
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health benefits risk pool, including coverage issued under N.D.C.C. ch. 26.1-08;
- A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government;
- A health benefit plan under section 5(e) of the Peace Corps Act Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e);
- A church plan; or
- A state’s children’s health insurance program funded through Title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.].
<table>
<thead>
<tr>
<th><strong>Domiciliary Care</strong></th>
<th>Domiciliary Care consists of a protected situation in a community or facility, which includes room, board, and personal services for individuals who cannot live independently yet do not require 24-hour Facility or nursing care.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Eligible Individual</strong></td>
<td>Any individual who meets the specific eligibility requirements of this Plan, as determined by the North Dakota Department of Human Services Division of Medical Services.</td>
</tr>
<tr>
<td><strong>Emergency Care Services</strong></td>
<td>Means: (1) <em>Within the Service Area</em>: covered health care services rendered by Participating or Nonparticipating Providers under unforeseen conditions that require immediate medical attention. Emergency care services within the Service Area include covered health care services from Nonparticipating Providers only when delay in receiving care from Participating Providers could reasonably be expected to cause severe jeopardy to the Member’s condition; or (2) <em>Outside the Service Area</em>: medically necessary health care services that are immediately required because of unforeseen illness or injury while the Member is outside the geographical limits of the Plan’s Service Area.</td>
</tr>
<tr>
<td><strong>Emergency Medical Condition</strong></td>
<td>A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy.</td>
</tr>
<tr>
<td><strong>Enrollee</strong></td>
<td>An individual who is covered by this Plan.</td>
</tr>
<tr>
<td><strong>ESRD</strong></td>
<td>The federal End Stage Renal Disease program.</td>
</tr>
<tr>
<td><strong>Expedited Appeal</strong></td>
<td>An expedited review involving Urgent Care Requests for Adverse Benefit Determinations of Prospective (Preservice) or Concurrent Reviews will be utilized if the Member, or Practitioner/Provider acting on behalf of the Member, believes that an expedited determination is warranted.</td>
</tr>
</tbody>
</table>
| **Experimental or Investigational Services** | Health Care Services where the Health Care Service in question either:  
  a. is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or  
  b. requires approval by any governmental authority and such approval has not been granted prior to the service being rendered. |
<p>| <strong>Facility</strong> | An institution providing Health Care Services or a health care setting, including Hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, Skilled Nursing Facilities, Residential Treatment Facilities, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings. |
| <strong>Health Care Services</strong> | Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease. |
| <strong>Hospital</strong> | A short-term, acute care, duly licensed institution that is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians. It has organized departments of medicine and/or major surgery and provides 24-hour nursing service by or under the supervision of registered nurses. The term “Hospital” specifically excludes rest homes, places that are primarily for the care of convalescents, nursing homes, Skilled Nursing Facilities, Residential Care Facilities, custodial care homes, intermediate care facilities, health resorts, clinics, Physician’s offices, private homes, Ambulatory Surgical Centers, residential or transitional living centers, or similar facilities. |
| <strong>Hospitalization</strong> | A stay as an inpatient in a Hospital. Each “day” of Hospitalization includes an overnight stay for which a charge is customarily made. Benefits may not be restricted in a way that is based upon the number of hours that the insured stays in the hospital. |
| <strong>Iatrogenic Condition</strong> | Illness or injury as a result of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error. |
| <strong>Individual Contract</strong> | A contract for Health Care Services issued to an individual for coverage under North Dakota Medicaid Expansion. |
| <strong>Institution for Mental Diseases (IMD)</strong> | A Hospital, institution, or other stand-alone Facility of 17 beds or more that is primarily engaged in providing diagnosis, treatment, or care for people with mental health and/or substance use disorders. Treatment provided to adults in an IMD is not reimbursable with federal dollars. The payment exclusion does not apply to treatment in Facilities that are part of larger medical entities that are not primarily engaged in the treatment of mental health and/or substance use disorders (generally tested by whether the majority of the patient population was admitted and treated for reasons other than mental health and/or substance use disorders), such as general hospitals or skilled nursing facilities. |
| <strong>Intensive Outpatient Program (IOP)</strong> | Provides mental health and/or substance use disorder outpatient treatment services during which a Member remains in the program a minimum of three (3) continuous hours per day and does not remain in the program overnight. |
| <strong>Intermediate Care</strong> | Intermediate Care means care in a facility, corporation or association licensed or regulated by the in the state in which it operates for the accommodation of persons, who, because of incapacitating infirmities, require minimum but continuous care but are not in need of continuous medical or nursing services. The term also includes facilities for the nonresident care of elderly individuals and others who are able to live independently but who require care during the day. |
| <strong>Maintenance Care</strong> | Treatment provided to a Member whose condition/progress has ceased improvement, or could reasonably be expected to be managed without the skills of a Practitioner/Provider. |
| <strong>Maximum Allowed Amount</strong> | The amount established by Sanford Health Plan using various methodologies for covered services and supplies. Sanford Health Plan’s Maximum Allowable Amount is the lesser of: a. the amount charged for a covered service or supply; or b. inside Sanford Health Plan’s service area, negotiated schedules of payment developed by Sanford Health Plan which are accepted by Participating Practitioners and/or Providers, or c. outside of Sanford Health Plan’s service area, using current publicly available data adjusted for geographical differences where applicable: i. Fees typically reimbursed to providers for same or similar professionals; or ii. Costs for facilities providing the same or similar services, plus a margin factor. |
| <strong>Medically Necessary or Medical Necessity</strong> | Medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment; consistent with the Member’s diagnosis or symptoms; appropriate according to generally accepted standards of medical practice; not provided only as a convenience to the Member or Provider; not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site; and provided at the most appropriate level of service that is safe and effective. For Members 19 or 20 only; Medical Necessity is defined under the EPSDT benefit as a covered service or item if it will do, or is reasonably expected to do, one or more of the following: a. Arrive at a correct medical diagnosis; b. Prevent the onset of an illness, condition or injury or disability in the individual or in covered relatives, as appropriate; c. Reduce, correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury or disability; d. Assist the individual to achieve or maintain sufficient functional capacity to perform age appropriate or developmentally appropriate daily activities. |
| <strong>Member</strong> | Any individual who is enrolled in the Plan. |
| <strong>Mental Health and/or Substance Use Disorder Services</strong> | Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), or the International Classification of Diseases (ICD), current editions. Also referred to as behavioral health, psychiatric, chemical dependency, substance abuse, and/or addiction services. |
| <strong>Natural Teeth</strong> | Teeth, which are whole and without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury. |
| <strong>Never Event</strong> | Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for Members and that indicate a real problem in the safety and credibility of a health care facility. Participating Providers are not permitted to bill the Plan or Members for services related to Never Events. |
| <strong>Non-Covered Services</strong> | Those Health Care Services to which a Member is not entitled and are not part of the benefits paid under the terms of this Contract. |
| <strong>Non-Participating Provider</strong> | A Provider that has not signed a contract with the Plan. |
| <strong>Nursing Services</strong> | Health Care Services which are provided by a registered nurse (RN), licensed practical nurse (LPN), or other licensed nurse who is: (1) acting within the scope of that person’s license, (2) authorized by a Provider, and (3) not a Member of the Member’s immediate family. |
| <strong>Out-of-Pocket Maximum Amount</strong> | This is the most you would pay out of your pocket each year. Once you reach your limit, you no longer have to pay copays to get care for the rest of the year. You will receive a letter telling you when you have reached this limit. |
| <strong>Participating Provider</strong> | A Practitioner/Provider who, under a contract with the Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Members with an expectation of receiving payment, other than Copays, directly or indirectly, from the Plan. |</p>
<table>
<thead>
<tr>
<th>Term</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Partial Hospitalization</td>
<td>Also known as day treatment; A licensed or approved day or evening outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for individuals with mental health and/or substance use disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment.</td>
</tr>
<tr>
<td>Physician</td>
<td>An individual licensed to practice medicine or osteopathy.</td>
</tr>
<tr>
<td>[The] Plan</td>
<td>Sanford Health Plan.</td>
</tr>
<tr>
<td>Practitioner</td>
<td>A professional who provides health care services. Practitioners are licensed as required by law.</td>
</tr>
<tr>
<td>Preventive</td>
<td>Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan.</td>
</tr>
<tr>
<td>Primary Care Practitioner (PCP)</td>
<td>A Participating Practitioner who is an Internist, Family Practice Physician, Pediatrician, or Obstetrician/Gynecologist who has been chosen to be designated as a PCP in the Plan’s Provider Directory. This person may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Member. Designated Primary Care Practitioners may also include Physician Assistants and Nurse Practitioners.</td>
</tr>
<tr>
<td>Prospective (pre-service) Review</td>
<td>Means Urgent and non-Urgent Utilization Review conducted prior to an admission or the provision of a health care service or a course of treatment.</td>
</tr>
<tr>
<td>Provider</td>
<td>A practitioner, institution, or organization that provides services for Plan Members. Examples of Providers include Hospitals, health care professionals, and home health agencies.</td>
</tr>
<tr>
<td>Prudent Layperson</td>
<td>A person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek Emergency medical treatment.</td>
</tr>
<tr>
<td>Qualified Mental Health Professional</td>
<td>Includes a licensed physician who is a psychiatrist; a licensed clinical psychologist who is qualified for listing on the national register of health service Providers in psychology; a licensed certified social worker who is a board-certified in clinical social work; or a nurse who holds advanced licensure in psychiatric nursing.</td>
</tr>
<tr>
<td>Residential Treatment Facility</td>
<td>An inpatient mental health or substance use disorder treatment Facility that provides twenty-four (24) hour availability of qualified medical staff for psychiatric, substance abuse, and other therapeutic and clinically informed services to individuals whose immediate treatment needs require a structured twenty-four (24) hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, substance abuse education/counseling. Facilities must be under the direction of a board-eligible or certified psychiatrist, with appropriate staffing on-site at all times. If the Facility provides services to children and adolescents, it must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children. Hospital licensure is required if the treatment is Hospital-based. The treatment Facility must be licensed by the state in which it operates.</td>
</tr>
<tr>
<td>Retrospective (Post-service) Review</td>
<td>Means any review of a request for a benefit that is not a Prospective (Pre-service) Review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication of payment. Retrospective (Post-service) Review will be utilized by Sanford Health Plan to review services that have already been utilized.</td>
</tr>
<tr>
<td>Room and Board</td>
<td>Includes but is not limited to the provision of meals, a place to sleep, laundry, and housekeeping. Room and board is not covered in a Residential Treatment Facility for Members ages 21 and older.</td>
</tr>
<tr>
<td>Serious Reportable Event</td>
<td>An event that results in a physical or mental impairment that substantially limits one or more major life activities of a Member or a loss of bodily function, if the impairment or loss lasts more than seven (7) days or is still present at the time of discharge from an inpatient health care facility. Serious events also include loss of a body part and death. Participating Providers are not permitted to bill Members or the Plan for services related to Serious Reportable Events.</td>
</tr>
<tr>
<td>Service Area</td>
<td>The geographic Service Area approved by the State’s Insurance Department</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>A facility that is operated pursuant to the presiding state law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly licensed physician.</td>
</tr>
<tr>
<td>Subscriber</td>
<td>An Eligible Member who is enrolled in the Plan. A Subscriber is also a Member or Enrollee.</td>
</tr>
<tr>
<td>[This] State</td>
<td>The State of North Dakota.</td>
</tr>
</tbody>
</table>
| **Urgent Care Request** | Means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination:  
| a. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson’s judgment; or  
| b. In the opinion of a Practitioner/Provider with knowledge of the Member’s medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request. |
| **Urgent Care Situation** | A degree of illness or injury, which is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours, such as stitches for a cut finger. |
| **Utilization Review** | A set of formal techniques used by the Plan to monitor and evaluate the medical necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Prospective (pre-service) Review, second opinion, Certification, Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review. |
| **Us/We** | Refers to Sanford Health Plan |
Attachment I: Summary of Benefits and Coverage

This page intentionally left blank. Please refer to your Summary of Benefits and Coverage which is attached to this Certificate of Coverage.