

Plan on the best fit.

SANFORD
HEALTH PLAN

**DHHS Health Care Reform Review Committee
Representative George Keiser, Chairman
November 10, 2015**

Chairman Keiser, members of the Health Care Reform Review Committee, I am Lisa Carlson, Director of Planning and Regulation at Sanford Health Plan. I appear before you to provide information regarding our experience in the Medicaid Expansion Program.

At the September 29, 2015 meeting the Committee asked for a copy of the ND Medicaid Expansion Sanford Health Plan Member Handbook to committee members, I would like to provide these at this time.

Medicaid Expansion Utilization Update

- Membership as of September 30, 2015 was 18,996
- The number of total inpatient days per every 1,000 members is 1,090 inpatient days – this is 4.6 times higher than the health plan's commercial population.
- The number of total prescriptions per every 1,000 members is 18,667 – this is 1.8 times higher than our commercial population. However, generic drug utilization is above average at 87.7 percent using generic vs. brand name drug.
- The average length of an inpatient hospital stay for our Medicaid Expansion members is 5.75 compared to 3.95 for the commercial membership.
- There are 1,212 ER visits per every 1,000 members, compared to 244.10 for the commercial membership.

These statistics reflect the more complicated and adverse health conditions many members experience. There is also no copay differential for members using an emergency room versus an urgent care center. With individuals who were not used to having insurance before Medicaid Expansion, some of these habits are hard to break and our care management team is focusing on member education of local acute care and after hour clinics and setting up members with a local primary care provider of their choice with members who have reoccurring ER visits.

Provider Network

We have successfully reached out to all human service centers and public health locations to contract and include them in our provider network. Our network also includes all major health systems in the state, however, we continue to contract with independent chiropractors, therapists and other ancillary providers to be in the network for Medicaid Expansion members. We continue to meet the contractual network access and availability standards for our members as outlined in the state contract.

Pharmacy Network

At the request of the Health Care Reform Review Committee meeting held in Bismarck on May 14, 2014 Sanford Health Plan and the Department of Human Services (DHS) were tasked with outlining the concerns of the North Dakota Pharmacists Association (NDPhA) and potential solutions that would be mutually agreeable to DHS, the Centers for Medicare and Medicaid Services (CMS), Sanford Health Plan and the NDPhA. Subsequently, a series of bi-weekly meetings were established for stakeholders to convene and vet through viable options. The end result was a multi-pronged solution that was considerate of the comments from our community pharmacies and ensures quality patient care and appropriate access to pharmacies for Medicaid Expansion Members.

Solution	Description
1 Adopt a broad network specifically for Medicaid Expansion	Effective August 1, 2014, Sanford Health Plan moved the Medicaid Expansion line of business to the broadest network. This resulted in an increase over existing contract reimbursement for those pharmacies who participated in multiple networks.
2 Sole community providers paid enhanced dispensing fee	<p>“Sole community” pharmacies defined as those with no competing pharmacy in their community.</p> <p>39 sole community pharmacies were moved to a Sanford custom network at rates as outlined in #1 above and with an enhanced dispensing fee.</p>
3 Created Pharmacy Engagement Program (PEP) for the North Dakota Medicaid Expansion Pharmacies	<p>In coordination with the Pharmacy Service Corporation, this PEP rewards participating pharmacies with enhanced rates when they meet the following standards:</p> <ol style="list-style-type: none"> 1. Antibiotic call: 3 days after an antibiotic is prescribed a pharmacist makes a follow-up call to see if medication being taken and patient is getting better. 2. Diabetic Patient: Download of glucose meter to evaluate testing compliance and outcome on a quarterly basis. 3. Adherence: Offer patient review of medication compliance on maintenance medications (Star rating meds) on a quarterly basis – offer a synchronized refill program. 4. Check blood pressure twice monthly on patients in first month after new start or dose change. 5. Review diabetic patients as to appropriateness of ACE and ARB therapy and follow-up with prescriber on a quarterly basis. <p>The Plan pays Pharmacists for the extra time spent in 15-minute increments up to \$80/hour. To date, we’ve had 14 pharmacies participate with 236 encounters.</p>
4 Create a new reimbursement model for Medicaid Expansion Pharmacies	<p>SHP to worked with DHS to move to a transparent reimbursement model for all pharmacies participating in the Medicaid Expansion Program that is factored into the 2015 bid and contract renewal. All participating Pharmacies were moved to a custom ESI network.</p>

For the Patient Engagement Program, the ND Pharmacy Service Corporation provides reports of patient interventions. The most common issue identified by pharmacists through this program is that members forget to take their medicines all together or on-schedule in order to experience the full beneficial effect of the drug. Pharmacists intervene by assisting with removing any barriers the member may have to taking the drug or taking the drug on schedule. This is an intervention that typically is only identified in the pharmacy setting since the pharmacist has access to the dispensing records to verify compliance. Another common intervention has been for the pharmacist to recommend starting a different medication. This is especially true for antibiotic use when members may choose to discontinue using an antibiotic due to an adverse reaction rather than approaching their healthcare provider for an alternative script.

Sanford Health Plan believes the Medicaid Expansion program is having a positive impact in North Dakota communities as evidenced in the progress discussed today.

Thank you for your time.

North Dakota
Medicaid Expansion Program

**Member
Handbook**

Plan on the best fit.

SANFORD
HEALTH PLAN

What's included in this member handbook

How to Contact Sanford Health Plan	2
Member Services	2
Tell Sanford Health Plan if you have Special Communication Needs	2
Translation Services	2
Services for the Deaf and Hearing Impaired	2
Services for Visually Impaired	2
Your Rights & Responsibilities	2
Let your wishes be known: Complete a Health Care Advance Directive	4
Your rights to make a Health Care Advance Directive:	4
Conscientious Objections	5
Know Your Benefits	5
What your plan covers and your costs	6
When you do not have copays	8
New Technology	8
Transportation Services	9
Services That Are Not Covered	9
When you have other health insurance coverage	9
When You May Have to Pay	9
If You Misuse Your Benefits	10
Coordinated Services Program (CSP)	10
How to get care	10
Check to see if your provider is in the network	10
Choose a primary care provider	10
Get Treatment for a Mental Health and/or Substance Use Disorder	1
When You Need to See A Specialist	1
If you need care from a specialty provider	1
Get More Information	9
If your provider leaves the network	9
Show Your ID Card	9
When Your Care Needs Prior-Approval	9
If Your Care is Out-of-Network	10
When you are Traveling outside the Sanford Health Plan Service Area	10
How to get care after normal business hours	10
Urgent care	10
Emergency care	11
Hospital care	11
How to get prescription drugs	11
Filling a prescription	12
Some drugs require prior-approval	12
When a drug is not covered	12
Keeping you in good health	12
Guidelines to good health	12
Guidelines to good health for pregnant women	12
Use the website to support your health goals	12
How Sanford Health plan takes care of you	12
Extra help when you have a chronic condition	13
Extra help when you are sick	13
Benefits for Members ages 19 and 20	13
My Sanford Nurse	13
Help giving up tobacco	13
How to read your Explanation of Benefits (EOB)	13
What to do if you have a concern	14
If you file a complaint	14
If you file an appeal	15
State Fair Hearing Process	15

Welcome to Sanford Health Plan!

The North Dakota Department of Human Services has decided you can be part of this program. This book is your guide to your health care plan. It tells you about your benefits and about what you need to know to make the most of your coverage. You will also find important information about how to choose a provider, what to do in an Emergency, and how to file a complaint.

How to Contact Sanford Health Plan

Member Services is available whenever you have a question or concern about benefits or services. Member Service staff can answer your questions, help you find a provider, and help you understand your benefits.

Business hours are Monday through Friday from 8 a.m. to 5 p.m., Central Time.

Department	Questions about . .	Email	Phone Number
Member Services	Benefits, claims, how to find a provider, how to file a complaint, and how to order another ID card	memberservices@sanfordhealth.org	Toll-free: (855) 305-5060 TTY/TDD: (877) 652-1844
Pharmacy and Prescription Drugs	Questions about what drugs are covered	um@sanfordhealth.org	Toll-free:(855) 276-7214 <i>Select option 1</i> TTY/TDD: (877) 652-1844
Medical Management	Prior-approval of health care services and questions about case management services	um@sanfordhealth.org	Toll-free: (855) 276-7214 <i>Select option 2</i> TTY/TDD: (877) 652-1844

Tell Sanford Health Plan if you have Special Communication Needs

Please call Member Services if you need help understanding plan information at (855) 305-5060 (*toll-free*). We can read forms to you over the phone and we offer free oral translation in any language through our translation services.

The North Dakota Department of Human Services Medical Service Division can also help with special communication needs. You may reach North Dakota Medical Services toll-free at (877) 543-7669 | ND Relay TTY: (800) 366-6888.

Translation Services

Member Services and Medical Management can arrange for translation services. Free written materials are available in several different languages and free oral translation services are available. Call toll-free (855) 305-5060 for help and to access translation services.

Spanish (Español): Para obtener asistencia en Español, llame al (800) 892-0675 (*toll-free*).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 892-0675 (*toll-free*).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 (800) 892-0675 (*toll-free*).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijjigo holne' (800) 892-0675 (*toll-free*).

Services for the Deaf and Hearing Impaired

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

Services for Visually Impaired

Please contact Member Services toll-free at (855) 305-5060 if you are in need of a large print copy or cassette/CD of this Handbook or other written materials.

Your Rights & Responsibilities

This Member Handbook is not a contract. This Handbook is designed to give you the basic information about your plan. The Handbook should not be used to determine if your health care expenses would be paid. Your Certificate of Coverage is your Policy, and the contract between you and Sanford Health Plan. It provides more detailed plan information. To get a copy of your Certificate of Coverage, call Member Services toll-free at (855) 305-5060 | TTY/TDD: (877) 652-1844 (*toll-free*).

You have the right to:

1. Get the health care described in this book
2. Be cared for with dignity and respect at all times and in all situations, no matter what your health status, including any current or past history of a mental health and/or substance use disorder; gender; race; religious beliefs; national origin; age; family status; ethnicity; disability; sexual orientation; or how you pay for services
3. Expect communications and other records pertaining to your care, including the source of payment for treatment, to be treated as confidential, including during conversations and exams, following North Dakota and federal rules and regulations
4. Get information on your diagnosis (to the degree known), available treatment choices, in a way that fits your condition and ability to understand, regardless of the cost or coverage benefit for available treatment options
5. Select a Primary Care Practitioner (PCP) of your choice, though you are not required to do so. If you are unhappy for any reason with the person you chose, you have the right to choose another PCP
6. Give informed consent before the start of any procedure or treatment
7. Participate in making decisions about your health care, including the right to refuse treatment
8. A clear grievance and appeal process for complaints (grievances) and comments, and a process to have your issues resolved in a timely manner
9. Make a complaint or appeal any decision about medical necessity made by Sanford Health Plan and its Providers
10. Get printed materials that describe important information about the Plan in a format that is easy to understand and easy to read
11. When you do not speak or understand the main language spoken in your community, the Plan will make reasonable efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a Provider that is able to communicate with you, as a Member.
12. Get information about the organization, its services and Providers, and Your Rights and Responsibilities, per federal rules and regulations [42 CFR 438.10]
13. Get a copy of your medical records and ask that they be corrected or changed
14. Make suggestions regarding Sanford Health Plan's rights and responsibilities policies
15. 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
16. Know the identity and professional status of individuals providing service to them and to know which Physician or other Provider is primarily responsible for your individual care. You also have the right to get information about the Plan's clinical guidelines and protocols.
17. Ask for and get, for free:
 - a. The Provider Directory, which is a list of health care providers in your network including names, locations, phone numbers and languages spoken by network providers, including those providers who are not accepting new patients
 - b. The professional education of your providers, including those who are board certified
 - c. The contact information for the state agency or licensing body that oversees complaints or corrective actions against a provider
 - d. Any prior-approval requirements, limits or non-covered services or drugs
 - e. Any limits on your freedom of choice among network providers
18. Be free to exercise all rights and that by exercising those rights, you will not be treated badly by the State, the Plan, and/or its participating providers

You have the responsibility to:

1. Know your Sanford Health Plan Certificate of Coverage
2. Know your Member Handbook
3. Use the Sanford Health Plan network of providers, hospitals, pharmacies, and clinics
4. Seek Emergency care at a Plan participating Emergency Facility whenever possible. In the event an ambulance is used, you should direct the ambulance to the nearest participating Emergency Facility unless your condition is so severe that you must use the nearest Emergency Facility. State law requires that the ambulance transport you to the Hospital of your choice unless that transport puts you at serious risk.
5. You are responsible for 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. Provide, as best you can, true and complete information about your current health, past illnesses, hospitalizations, medications, and other information relating to your health
7. Report unexpected changes in your health to the responsible Provider
8. Speak up when you don't understand a service, treatment, or what you are being asked to do
9. Call Member Services with any questions
10. Seek services for non-emergency care through a primary care provider, clinic or urgent care facility. The emergency room should only be used when the clinic or urgent care center is closed or when a condition arises that is severe and needs care right away.
11. Request prior-approval by Sanford Health Plan when referred for out-of-network services, or have your doctor's office do it for you.

12. You are responsible for keeping appointments and, when you are unable to do so for any reason, for notifying the responsible Provider or the Hospital
13. Carry your Plan Member ID card with you, and have Member identification numbers available when contacting the Plan.
14. Be involved in decisions about your health
15. Be friendly and nice to providers, their staff and other patients, and Sanford Health Plan employees
16. Protect your ID card against misuse
17. Call Member Services right away if your card is lost or stolen, or you suspect fraud
18. You are responsible for your actions if you refuse treatment, or do not follow your doctor's instructions
19. You are responsible for following your treatment plan as recommended by the provider primarily responsible for your care. You are also responsible for participating in treatment and understanding, to the degree possible, your 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.
20. You are responsible for notifying your local County Social Service Office within *ten (10)* days if you change your name, address, or telephone number. If unable to reach your local County Social Service Office, contact the North Dakota Department of Human Services Medical Service Division at (877) 543-7669 (*toll-free*) | ND Relay TTY: (800) 366-6888 (*toll-free*).

You are responsible for notifying your local County Social Service Office within ten (10) days if you have any changes that may affect your membership eligibility or access to services. If unable to reach your local County Social Service Office, contact the North Dakota Department of Human Services Medical Service Division at (877) 543-7669 (*toll-free*) | ND Relay TTY: (800) 366-6888 (*toll-free*).

Let your wishes be known: Complete a Health Care Advance Directive

There may come a time when you cannot tell others how you want to be cared for and about your choices for health care. By making a plan now, you can choose how you want your wishes to be carried out.

Under North Dakota state law (N.D.C.C. ch. 23-06.5), you have the right and responsibility to make the decisions relating to your own health care, including the decision to have health care provided, withheld, or withdrawn. This means you can make decisions about your medical care, you have the right to accept or refuse treatment, and you can create instructions, what is called a "Health Care Advance Directive" about how you want to get medical care if you are unable to make decisions. For example, if you are unconscious or unable to speak.

A **Health Care Advance Directive** is a written document that has your health care instructions, a Durable Power of Attorney for Health Care, or both.

Your rights to make a Health Care Advance Directive:

The steps listed below can help.

1. First, let family, friends and your provider know what kinds of treatment you do or don't want.
2. Second, you can appoint someone you trust to make health care decisions for you if you are unable to express your wishes. This person will be your "Agent".
3. Third, it is best if you put your thoughts in writing.
4. Once you have your thoughts in writing, you are ready to finish your Health Care Directive. It must be signed by you in front of a notary public or at least two witnesses, who are at least eighteen (18) years old. The notary public and your witnesses may not be:
 - a. in charge of your estate or will if you die; or
 - b. your spouse; or
 - c. a person related to you by blood, marriage, or adoption; or
 - d. someone who would get money or other benefits from your death.

NOTE: You do not have to use a lawyer, but you may wish to speak with one about this.

What is a Durable Power of Attorney for Health Care?

A **Durable Power of Attorney for Health Care** allows you to give some other person the legal right to make health care choices for you if you are not able to make them yourself.

What is a Living Will?

A **Living Will** is a paper that gives instructions to your provider for when you want life-aiding care to be given, withheld or withdrawn.

You can sign a Living Will - a record that sets out steps for future care. A durable power of attorney for health care is a type of living will.

Living wills can be signed and copies should go to:

- The person you trust for making choices in the event you are not able to speak for yourself;

- The hospital where you are most likely to be treated; and
- Your provider.

You can change your mind about these documents at any time. Sanford Health Plan can help you understand or help you get these documents. We respect your rights if you want to make a Health Care Advance Directive, but you are not required to make one. Under State law (N.D.C.C. § 23-06.5-10), you can choose whether to have a Durable Power of Attorney, a Living Will, or a Health Care Advance Directive; not having these documents will not change your right to quality health care benefits. Services covered by the Plan will not be refused if these documents are not in place. Their only purpose is to let others know what you want if you cannot speak for yourself.

Conscientious Objections

A healthcare provider may not follow your wishes if they go against his or her conscience. This means it is possible that a specific treatment or medication you list in your advance directive, living will or durable power of attorney may be provided or denied to you because the provider cannot, in good conscience, authorize it. If so, he or she will help you find someone else who will follow your wishes. In addition, health care facilities are not required to implement an advance directive if there is an institution-wide conscientious objection and state law allows such an objection. (N.D.C.C. §§ 23-06.5-09 to 23-06.5-13).

For more information on advance care directives, visit www.sanfordhealthplan.com or call Member Services toll-free at (855) 305-5060.

Know Your Benefits

What your plan covers and your costs

When you have to get health care services, you must pay the copayment (“copay”) amount listed below. This is not a complete list of benefits, to view your benefits, limits and list of non-covered services, you must read your Certificate of Insurance. To get prior-approval, you or your provider should call toll-free (855) 276-7214 | TTY/TDD: (877) 652-1844 (toll-free).

Your Benefits	Your Cost if You Use an In-Network Provider	
	If you are ages 21 and older	If you are ages 19 and 20
Out-of-Pocket Maximum This is the most you would pay out of your pocket each calendar year. Once you reach your limit, you no longer have to pay copays to get care for the rest of the year. You will get a letter telling you when you have reached this limit.	5% of your household’s countable earnings.	
Medical Office Visit Includes visits to physicians, nurse practitioners, and physician assistants	\$2 per office visit	\$0 per office visit
Rural Health Clinic (RHC) Office Visit	\$3 per office visit	\$0 per office visit
Federally Qualified Health Center (FQHC) Office Visit	\$3 per office visit	\$0 per office visit
Indian Health Services (IHS) Office Visit Includes visits to Urban Indian Health, and referrals through Contract Health Services (CHS)	\$0 per office visit if you are a Native American who gets, or is eligible to get, services from Indian Health Services (IHS) or through referral by Contract Health Services (CHS)	
Preventive Care Office Visit Includes health screenings, prenatal and postnatal care, and immunizations	\$0 per office visit	
Diagnostic Tests Includes x-rays, blood work, MRIs	\$0 per office visit	
Inpatient Hospital Stay You must call to get prior-approval.	\$75 per stay	\$0 per stay

Your Benefits	Your Cost if You Use an In-Network Provider	
	If you are ages 21 and older	If you are ages 19 and 20
Outpatient Surgery You must call to get prior-approval.	\$0	
Home Health Care You must call to get prior-approval.	\$0	
Skilled Nursing Facility Services You must call to get prior-approval.	\$0	
Outpatient Mental Health and Substance Use Disorder Services Includes office visits to physicians, nurse practitioners, physician assistants, clinical psychologists, licensed clinical social workers, licensed chemical dependency counselors, intensive outpatient/partial hospitalization programs (day treatment).	\$2 per office visit \$2 per course of treatment for all other services, including partial hospitalization/intensive outpatient programs	\$0 per office visit \$0 per course of treatment for all other services, including partial hospitalization/ intensive outpatient programs
Inpatient Mental Health and Substance Use Disorder Services You must call to get prior-approval. Includes overnight hospital stays, residential care, substance use disorder inpatient (overnight) treatment programs, and inpatient medical detoxification.	\$75 per stay Benefit limited only to certain facilities. <i>For Members ages 21 and older, Room and Board charges excluded for inpatient residential care facilities.</i>	\$0 per stay
Durable Medical Equipment and Prosthetic Devices You must call to get prior-approval.	\$0	
Hospice Care You must call to get prior-approval.	\$0	
Habilitation & Rehabilitation Services 30 visits per therapy per calendar year.		
Physical therapy office visit	\$2 per visit	\$0
Occupational therapy office visit	\$2 per visit	\$0
Speech therapy office visit	\$1 per visit	\$0
Habilitative therapy office visit	\$2 per visit	\$0
Chiropractic Care Covered for spinal manipulations. Limited to 20 visits per calendar year.	\$1 per visit	\$0
Dental Office Visits Covered for Members ages 19 and 20 only.	-----Not Covered-----	\$0 per office visit
Eye Exam Office Visit Includes optometrists and ophthalmologists	\$2 per office visit Covered only when medical vision exam needed for eye disease or injury of the eye. <i>Adult routine eye exams are not covered.</i>	\$0 per office visit <i>Includes routine eye exams</i>
Foot Exam Office Visit Includes podiatrists	\$3 per office visit	\$0 per office visit

Your Benefits	Your Cost if You Use an In-Network Provider	
	If you are ages 21 and older	If you are ages 19 and 20
Emergency Room Visit You do not have to pay the copay if you are admitted to the hospital.	\$3 per Emergency room visit that is not an Emergency (see <i>Emergency care</i> section)	\$0
Emergency Transportation Includes ground and air ambulance services.	\$0	
Non-Emergency Transportation For medical reasons only. You must call to get prior-approval and to schedule your ride.	\$0	
Prescription Drugs <i>Listed on the Formulary:</i> Generic Drugs Brand-Name Drugs Birth Control Drugs or Devices Drugs not listed on the formulary	\$0 copay per 30-day supply \$3 copay per 30-day supply \$0 copay per 30-day supply You pay all costs.	\$0 copay per 30-day supply \$0 copay per 30-day supply \$0 copay per 30-day supply You pay all costs.

When you do not have copays

You do not have any copayments if you are:

- Ages 19 and 20.
 - See the *Early Periodic Screening, Diagnosis and Treatment Benefits for Members ages 19 and 20* section of this handbook for other benefits
- Pregnant.
- An American Indian enrolled in a federally recognized tribe or have gotten care at or is eligible to get care from Indian Health Services (IHS), a tribal health program, or urban Indian health program, or through referral from one of these programs
 - To get this benefit of having no copayments as an American Indian, one of the above would have to apply based on the available information from the application you submitted and noted within the North Dakota Humans Services Eligibility System. If you are not receiving this benefit and believe you are eligible for it contact your local County Social Service Office or the North Dakota Department of Human Services toll-free at (877) 543-7669 | ND Relay TTY: (800) 366-6888 to make sure it appropriately indicated with the system.
- Live in an institution such as:
 - Nursing Facility, long term care
 - Swing bed, long term care
 - Intermediate Care Facility for the Intellectually Disabled (ICF/ID)
 - State Hospital
 - Anne Carlsen Center for Children

New Technology

Experts advise Sanford Health Plan on changes in medical practice and technology. This helps keep Sanford Health Plan stay up-to-date on new technology and make decisions about which new services to cover. Please see your Certificate of Coverage for more information.

Transportation Services

Sanford Health Plan's ride service can take you to your provider's office for routine, non-Emergency care listed on the included chart. The service can also take you to pick up your prescriptions or durable medical equipment on the day of your appointments. You must call the Sanford Health Plan Transportation Coordinator toll-free at (800) 236-4907 or TTY/TDD: 1-877-652-1844 (toll-free) for prior-approval and to set up a ride. Please remember to call two (2) days before your appointment if you need a ride. If you need a ride to the pharmacy to pick up your prescription drugs, do not wait until you are out of your medicine before you call for a ride. If you need to cancel a ride, call at least four (4) hours before your appointment time.

Rides for nonmedical services aren't covered. For Emergency transportation, always call 911.

Services That Are Not Covered

Some services and drugs aren't covered. Below are some examples. For a complete list, please see your Certificate of Coverage.

If you need another copy, call Member Services, and the Plan will mail you one free of charge.

These Services are Not Covered (Excluded):

- Care from a provider who is not in the Sanford Health Plan network, unless it's Emergency care or prior-approved from Sanford Health Plan
- Any care before you are eligible for the plan or after your coverage with this plan ends, as determined by the North Dakota Department of Human Services Medical Service Division
- Marriage or bereavement counseling; pastoral, financial or legal counseling; or custodial care counseling
- Inpatient health care services received at an Institution for Mental Disease (IMD) for Members ages 21 and older
- Care that is not medically needed
- Vaccines you need to travel outside the USA
- Gender reassignment surgery
- Reversal of sterilizations
- Acupuncture
- Care that is also covered by any other government or social agency, unless applicable law requires the Plan to coordinate or provide primary coverage for the same
- Illness or injury related to war or military services covered by another governmental agency or payor, , unless applicable law requires the Plan to coordinate or provide primary coverage for the same
- Work-related illness or injury
- Charges that result from missing an appointment
- Personal hygiene or convenience items
- Fitness equipment, health club membership
- Treatment for food allergies (e.g., food drops, etc.) or other non-standard allergy services
- Care given that should have had prior-approval from Sanford Health Plan
- Elective abortions
- Infertility treatment
- Experimental or investigational procedures or equipment not part of an Approved Clinical Trial
- Elective cosmetic services
- Health care received outside of the United States
- These drugs are not covered:
 - Cosmetic drugs or drugs used for cosmetic purposes
 - Drugs used for experimental or investigational purposes
 - Prescriptions filled after you are no longer enrolled in the plan
 - Prescriptions filled at a pharmacy not in the Sanford Health Plan network
 - New drugs not yet added to the covered drug list (formulary)
 - Replacement prescriptions resulting from loss, theft or mishandling
 - Drugs acquired without cost to the providers or included in the cost of other services or supplies

When you have other health insurance coverage

In some cases, you may be covered by another health plan. If so, Sanford Health Plan will work with the other company to share the cost of care. If you have other health insurance, please tell Member Services so that Sanford Health Plan can find out whether another company should pay for some of your care.

When You May Have to Pay

There are some situations where you might be responsible for paying for your health care services, and Sanford Health Plan does not cover the costs of your care. This may happen when:

- 1) Your provider has told you about its policy for billing patients who get services that are not covered by their insurance; if you agree to still get care, you may be responsible for paying the provider directly if the service is not covered by the Plan; or
- 2) You have told the Provider, often in writing by signing a form, before you got care that you would pay, even if the care wasn't covered by Sanford Health Plan; or
- 3) You knew services weren't covered by Sanford Health Plan, or you chose not to get prior-approval from the Plan, and told the Provider, often in writing by signing a form, that you would pay if the Plan denied your claim; or
- 4) You choose to obtain or continue to receive denied services throughout an appeal process to either the Plan or through a State Fair Hearing and it is determined that the services would remain denied; or
- 5) You were not eligible for North Dakota Medicaid Expansion coverage during the time when you received the health care service.

If you misuse your benefits

Sanford Health Plan's goal is to make sure that members get the care they need while being responsible with resources. If there is a pattern of using services that are not needed or abuse/misuse of benefits, or you commit fraud, Sanford Health Plan may restrict you (lock you in) to a certain provider, clinic or pharmacy. This program is called the "Coordinated Services Program (CSP)". Sanford Health Plan will send you a letter if this happens. The letter will tell you what provider, clinic or pharmacy you must use and how long you'll be in the CSP (lock-in) program.

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 Service 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 health care services
- 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 lock-in requirements set forth in 42 CFR §431.54.

How to get care

Check to see if your provider is in the network

Sanford Health Plan has contracts with over 15,000 providers in North Dakota, South Dakota, Minnesota, Iowa, and Nebraska. These doctors, specialists, hospitals, labs and other health care facilities make up the provider network. This book refers to the list of contracted providers as the "network" or the "Provider Directory." You must use these providers when you need health care.

Sanford Health Plan's Provider Directory is a list of everyone in the network. For a copy of the Provider Directory, call Member Services toll-free at (855) 305-5060 | TTY/TDD: (877) 652-1844 (*toll-free*) or view it online at www.sanfordhealthplan.com.

You can choose to see any of the health care providers in the network. If you are going to get health care services outside of the network, you or your Provider must get prior-approval from Sanford Health Plan. If you do not get prior-approval, you will have to pay the bill and the health plan may not pay anything, unless your care was urgent or emergent. When you get services from a Provider not in the network, you are getting services "Out-of-Network" and there is no coverage through the North Dakota Medicaid Expansion Program unless you or your Provider gets prior-approval from the Plan or unless the care was urgent or emergent.

Choose a primary care provider

You may choose and see any of the primary care providers in the network. If the provider you have now is in the network, he or she can be your provider. But if your current provider is not in the Sanford Health Plan network, you will need to choose a provider in the network. You may want to choose a provider who is close to your home.

A primary care provider can be a:

- Family or general practice provider
- Nurse Practitioner
- Physician's Assistant (PA)
- Internist
- Pediatrician
- Obstetrician/gynecologist (OB/GYN)
- A health site such as a federally qualified health center (FQHC), Indian Health Service (IHS) facility, or a rural health clinic (RHC)

Women: You can see an obstetrician or gynecologist in the Sanford Health Plan network without a referral from your primary care provider. You can do this even if your obstetrician or gynecologist isn't your primary care provider. You may also get other women's health specialist services from any network provider. You don't need a referral.

Pregnant women: Women may get routine obstetrics and gynecology care from their primary care provider. You may also get this care from an obstetrician or gynecologist who belongs to the Sanford Health Plan network. You don't need a referral for

maternity care, including office visits and Pap tests. Pregnant women may also be able to see an out-of-network provider; but you must call to get prior-approval. It is important for you to contact your local county social service office when you become pregnant; they will help you decide if you should switch to the traditional Medicaid program. **Please note that this plan does not cover babies.**

If you are pregnant or think you are pregnant, it's very important that you see a provider as soon as possible. Call Sanford Health Plan toll-free at (855) 276-7214 | TTY/TDD: (877) 652-1844 (*toll-free*) to enroll in the "Healthy Pregnancy Program," where you will get information about extra services just for you while you are pregnant.

Family planning services: Sanford Health Plan offers family planning services through your primary care provider, an obstetrician, or gynecologist. Call Member Services if you need help you need help finding a clinic. You may visit any family planning clinic in our network without a referral.

Native American/Alaska Native Primary Care Provider Choice: Care you get from the Indian Health Service (IHS), Indian Tribes, Tribal Organizations, Urban Indian Organizations, or through referral under contract health services (CHS), is covered by Sanford Health Plan in-network. If you already have a Primary Care Provider at one of these places, you can keep that provider and the services he or she gives you will be in-network. If you are eligible to get care at these facilities, the same rights apply and you can pick a PCP who works at that facility. Sanford Health Plan pays an Indian health care provider or a health care provider through referral under CHS the same as any other provider in the network. Call Member Services if you need help you need help finding an Indian health care provider. You may visit any Indian health care provider without a referral.

Get Treatment for a Mental Health and/or Substance Use Disorder

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: 1-800-231-7724 TTY: (701) 774-4692	Region V, Fargo: 24-hour Crisis Line: (701) 298-4500 Toll-Free: (888) 342-4900
Region II, Minot: 24-hour Crisis Line: (701) 857-8500 Toll-Free Crisis Line: (888) 470-6968 TTY: (701) 857-8666	Region VI, Jamestown: 24-hour Crisis Line: (701) 253-6304
Region III, Devils Lake: 24-hour Crisis Line: (701) 662-5050 [collect calls accepted] Toll-Free: (888) 607-8610 TTY: (701) 665-2211	Region VII, Bismarck: 24-hour Crisis Line: (701) 328-8899 Toll-Free: (888) 328-2112
Region VI, Grand Forks: 24-hour Crisis Line: (701) 775-0525 Toll-Free: (800) 845-3731	Region VIII, Dickinson: 24-hour Crisis Line: (701) 227-7500 (during business hours) (701) 290-5719 (<i>after</i> business hours)

These numbers are available 24-hours a day. You should also keep in touch with any mental health and/or substance use disorder treatment practitioner, as well as your primary care provider about any worries you have. These people can help get you well and help you stay well.

If you have questions about mental health and/or substance use disorder treatment benefits provided by Sanford Health Plan, contact Medical Management toll-free at (855) 276-7214 | TTY/TDD: (877) 652-1844 (*toll-free*).

When You Need to See a Specialist

If you need care from a specialty provider

You may need medical care that your primary care provider is not able to provide. He or she may ask you to see a specialist. A specialist is a provider with training in a specific area of medicine, such as a dermatologist – a provider who checks the skin.

When your primary care provider asks you to see a specialist, this is called a referral. You or your primary care provider do not need prior approval from the plan for you to see an in-network specialist and Sanford Health Plan will pay for the specialty care if medically necessary. When you are referred to an out-of-network specialist, you or your primary care provider must call for prior-approval from the plan. If you do not get prior-approval, you will have to pay the bill and the health plan may not pay anything, unless your care was urgent or emergent.

Mayo Clinic Health System in Rochester, Minnesota

If your provider refers you to Mayo, you or your provider must call for prior-approval. Call Medical Management toll-free at (855) 276-7214 | TTY/TDD: (877) 652-1844 (*toll-free*) for prior-approval.

Get More Information

You can ask for information about your provider at any time

Call Member Services toll-free at (855) 305-5060 and they can answer these questions about your provider:

- Are they on the Sanford Health Plan provider network list?
- What are the professional credentials of Sanford Health Plan's network providers?

- Can I get a list of providers who speak languages other than English?
- What are the prior-approval requirements, limits, restrictions or exclusions?
- How does Sanford Health Plan pay its providers? **NOTE:** Sanford Health Plan doesn't pay providers in a way that would prevent you from getting the care you need.

If your provider leaves the network

Sometimes providers leave the network. If your provider leaves the network, Sanford Health Plan will let you know and help you find a new provider. If your provider leaves the Sanford Health Plan network, you may be able to stay in his or her care for a period of time. If you are pregnant or have a terminal illness, you may be able to continue treatment with your provider even after he or she leaves the network. This is called continuity of care.

If you would like Sanford Health Plan to consider continuity of care for you, please call Medical Management toll-free at (855) 276-7214 | TTY/TDD: (877) 652-1844 (*toll-free*). Your request will be reviewed. The decision will be based on your condition.

Show Your ID Card

You will get a Sanford Health Plan Identification (ID) Card in the mail. Show your ID Card each time you visit a provider. You will also need it to get a prescription filled. **If you need to replace a lost card, please call Member Services toll-free at (855) 305-5060 | TTY/TDD: (877) 652-1844 (*toll-free*) and a new one will be sent to you.**

Here is what your ID card looks like:

Sanford Health Plan

ID: 21003000104
 JOHN DOE
 Grp: MDX0010001
 ND Medicaid Expansion
 In Network Office Visit:
 \$2 Copay

RxBIN: 003858
 RxPCN: A4
 RxGrp: SANFRX
 ADMINISTERED BY
 EXPRESS SCRIPTS

Members: For urgent or emergency care when you are out of the local service area, seek treatment at the nearest medical facility or call 911. Notify Sanford Health Plan of an admission as soon as it is reasonably possible and no later than 10 days after physically or mentally able to do so.
Eligibility: This card is for identification purposes only. It does not constitute proof of eligibility.
 20131215

View Provider Directory at: sanfordhealthplan.com
 Benefits & Eligibility: 1-855-305-5060
 Precertification/Authorization: 1-855-276-7214
 Pharmacy Use Only: 1-800-824-0898
 Payor ID: 91184
 Submit claims to: Sanford Health Plan
 PO Box 91110
 Sioux Falls, SD 57109-1110

PHCS Healthy Directions MultiPlan

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

Annotations:

- You have a unique ID number.
- Your group ID number.
- The amount you pay each time you go to the doctor.
- Call this number for benefit and claim questions or to find a doctor.
- Call this number to get prior-authorization of services or if you have questions on your drug coverage.
- Your pharmacist can call this number with questions about covered drugs.
- This logo shows you have drug coverage.
- This set of logos indicates you have national coverage while traveling out of the service area.

When Your Care Needs Prior-Approval

Most of the care you need will be covered by Sanford Health Plan. But, some care needs prior-approval from Sanford Health Plan before your appointment. This process guarantees your care will be covered. Prior-approval is the process of getting an approval from Sanford Health Plan for certain prescriptions, treatments, or care

Health care providers that are part of the Sanford Health Plan network will send Sanford Health Plan the information needed to approve the care. However, you are ultimately responsible for making sure the services listed below get prior-approval.

Below are some examples of services you must call Sanford Health Plan toll-free at (855) 276-7214 | TTY/TDD: (877) 652-1844 (*toll-free*) to get prior-approval:

- Any overnight stay that is not an Emergency in a hospital or other facility, such as a stay in a skilled nursing or a residential treatment facility
- Care from a hospital, clinic, provider or specialist that is not in the Sanford Health Plan network

- Hospice, end-of-life care
- Health care workers in your home
- Outpatient surgeries
- Durable medical equipment, orthotics and prosthetics
- Organ or tissue transplant services
- Genetic tests
- Specialty drugs, such as injectable drugs, infusible drugs and high cost medications (for example chemotherapy drugs)
- Insulin pumps and infusion devices
- Surgery for morbid obesity
- Cochlear implants

For a complete list of services that must have prior-approval for the Plan to pay, call (855) 276-7214 | TTY/TDD: (877) 652-1844 (toll-free) or refer to your Certificate of Coverage.

There is a time limit for Sanford Health Plan to make a decision on your prior-approval request.

Sanford Health Plan will review your request and notify you of a decision within 14 calendar days of your request. Sanford Health Plan may take up to 14 business days more to make a decision if more information is needed from your provider. Sanford Health Plan will send you a letter if this happens.

If your request is urgent, you have the right to a faster (expedited) process. You or your provider can ask for an expedited prior-approval if:

- Waiting the usual number of days for a prior-approval will hurt your health or life; or
- You are in pain and your provider says that you need the care to stop the pain.

To request an expedited review, you or your provider should call toll-free (855) 276-7214. Sanford Health Plan will make a decision on the expedited request as soon as needed for your health and within 3 business days.

If Your Care is Out-of-Network

Out-of-network services are medical services provided by providers who aren't in the network. Sanford Health Plan usually doesn't pay for these services. Sanford Health Plan would pay only if the services are normally covered but a network provider isn't able to provide them. You or your provider must call Sanford Health Plan to get prior-approval before receiving any out-of-network services, unless it is an Emergency.

When you are traveling outside the Sanford Health Plan Service Area

Emergency and Urgent Care

If you have a medical Emergency when you are outside the Sanford Health Plan service area, including out of the state, call 911 or seek help at the nearest medical facility. Please contact your primary care provider within 10 days. He or she will arrange your follow-up care. Emergency and urgent care is not covered outside of the United States. **This Plan does not cover any services received outside the United States.**

Non-urgent or non-Emergency care

When you are outside of the service area, Sanford Health Plan does not pay for routine care. Only urgent and emergency care is paid for when you are outside of the service area. **This Plan does not cover any services received outside the United States.**

How to get care after normal business hours

Business hours are Monday through Friday, 8 a.m. through 5 p.m., Central Time. Your network primary care provider has agreed to be available 24 hours a day, 7 days a week for Emergency and urgent care. Be sure to call during normal business hours (usually Monday through Friday, 8 a.m. to 5 p.m.) for routine care, and only call after hours for urgent care. Your provider may see you, or send you to an urgent care center or to another provider.

Urgent care

Urgent care centers provide services for illnesses that need to be treated within 48 hours such as the flu, high fevers or a sore throat. Other examples are ear infections, eye irritation and low back pain. If you fell and have a sprain or pain, it can be treated at an urgent care center.

Urgent care centers are helpful if you need care quickly but can't see your primary care provider. You don't need a referral or prior-approval to go to an urgent care center. Urgent care centers are listed in the Provider Directory. If you go to an urgent care center, we encourage you to contact your primary care provider within 24 hours. He or she can arrange your follow-up care. If you aren't sure if you need urgent care, call your provider. He or she may be able to treat you in his or her office.

Emergency care

You don't need a referral or prior-approval to get Emergency care. An Emergency is a health problem that starts suddenly and needs care right away. If calling your primary care provider first would delay getting the help you need in an Emergency, go to the nearest Emergency room or call 911. You may go to any Emergency facility.

A Medical Emergency means if you don't get immediate medical attention:

- Your health, or the health of your unborn baby (if you're pregnant), may be in danger.
- Your body functions may be seriously damaged.
- Any organ or part of your body may not work properly again.

Emergency conditions may include:

- Severe pain
- Unusual chest pain
- Problems breathing
- Puncture wounds
- Nonstop bleeding
- Broken bones
- Severe bites or burns
- Blows to the head
- Sudden loss of strength or feeling in the arms or legs

Emergency services are:

- Given by a qualified, licensed health care provider
- Needed to evaluate or stabilize you in an Emergency

Once you are in stable condition after an Emergency, you may need more care to get better or fix your condition. This is called post-stabilization. The Health Plan covers Emergency services necessary to stabilize Members without prior-approval. If you get Emergency care, please contact your primary care provider as soon as reasonably possible, and no later than ten (10) calendar days after physically or mentally able to do so. He or she can arrange your follow-up care. Sanford Health Plan also offers extra help when you are seriously ill or injured. See the section called *How Sanford Health Plan takes care of you* for details. **Emergency and urgent care is not covered outside of the United States.**

Hospital care

Inpatient and outpatient non-Emergency services must be provided at a network hospital. You or your provider must call Sanford Health Plan for prior-approval. Sanford Health plan covers ambulance transportation to hospitals and between a hospital and a skilled nursing facility. If you get Emergency care at an out-of-network hospital or facility, Sanford Health Plan may transfer you to a network hospital when it is safe to do so.

How to get prescription drugs

Your drug benefit covers most of the generic medicines approved by the U.S. Food and Drug Administration (FDA). Drugs also include some over-the-counter medicine such as pain relievers, laxatives, iron tablets and family planning drugs or supplies. For Sanford Health plan to cover these, you will need a prescription from your provider.

You can fill prescriptions at any pharmacy that accepts your Sanford Health Plan ID card. To find a pharmacy, please refer to the Provider Directory online at www.sanfordhealthplan.com or call Member Services toll-free at (855) 305-5060 and ask for it to be mailed to you.

To see which medicines are covered by Sanford Health Plan, refer to the formulary on the website at www.sanfordhealthplan.com or call Member Services toll-free at (855) 305-5060 and ask for it to be mailed to you. The formulary is a list of preferred drugs that are covered when prescribed by a Sanford Health Plan provider and filled at a pharmacy in the Sanford Health Plan network. If a drug is not on the formulary, it may not be covered by Sanford Health Plan.

Brand name versus generic

There's little difference between a brand name medicine and its generic version. Generic versions have the same ingredients as the brand name. They may have a different color and shape, but these are the only differences. Generics also are much less expensive. Your pharmacy will usually fill your prescription with the generic version. If your provider feels the brand name version is needed and can't be substituted with the generic version, he or she must ask Sanford Health Plan for prior-approval for the brand name drug.

Filling a prescription

You may fill prescriptions at any pharmacy in the network. Sanford Health Plan's network has nearly 200 pharmacies in the state and 60,000 in the country. This includes both chain stores and independently owned stores. Pharmacies who accept Sanford Health Plan ID Cards are listed in the Sanford Health Plan Provider Directory, which is available online at

www.sanfordhealthplan.com or by calling Member Services toll-free at (855) 305-5060. Just like Sanford Health Plan has a network of providers, the plan also has a network of pharmacies.

For specialty drugs: If you take specialty drugs for complex or rare conditions, such as arthritis, multiple sclerosis, hepatitis C or others, you must call Sanford Health Plan's *Specialty Drug Program* (Accredo) at (866) 333-9721. The *Accredo* program will arrange for these drugs to be mailed to you or your provider's office within 24 to 48 hours after you call.

Some drugs require prior-approval

Sometimes Sanford Health Plan must prior-approve certain drugs before they are covered. Sanford Health Plan may also limit the quantity that is covered. In some situations, you must meet certain conditions, try other medicines that are on the preferred drug list, have certain medical conditions or be a certain age.

Sanford Health Plan reviews all provider requests. Sanford Health Plan complies with state laws requiring coverage for the use of certain drugs "off-label". Sanford Health Plan follows a consistent process while reviewing requests to cover off-label use of drugs approved by the FDA.

When a drug is not covered

Some drugs may not be covered. This might include drugs that aren't on the formulary, drugs that require prior-approval or drugs that aren't covered by Sanford Health Plan. It may also include drugs that are used for purposes other than their original intent. This is called off-label use.

Keeping you in good health

It is better for you to see your primary care provider when you are healthy so that he or she can work with you to keep you healthy instead of just trying to treat you when you are sick. When you choose a primary care provider, that person can give you yearly physical exams and immunizations. Sanford Health Plan will mail you information to help you stay fit and live a healthy life - physically and mentally.

Guidelines to good health

Sanford Health Plan has developed guidelines for good health, called the Preventive Health Guidelines. These guidelines help you and your provider make sure you get the tests and care you need to stay healthy at each stage in your life. If you would like a copy of the Plan's Preventive Health Guidelines or a vaccine schedule, please contact Member Services toll-free at (855) 305-5060 or visit www.sanfordhealthplan.com/memberlogin.

Guidelines to good health for pregnant women

Staying healthy is important to both moms and babies. See your provider as early as possible and keep all your appointments. Follow your provider's directions. These prenatal visits are covered by Sanford Health Plan. It is important for you to contact your local county social service office when you become pregnant; they will help you decide if you should switch to the traditional Medicaid program. **Please note North Dakota's Medicaid Expansion coverage provided by Sanford Health Plan does not cover babies.**

Sanford Health Plan has a "Healthy Pregnancy" program for soon-to-be moms. This program helps parents learn about the new baby, take care of moms-to-be, eat right and become a new mom and dad. Call toll-free (855) 305-5060 and tell Sanford Health Plan when you know you're pregnant. You will get information about the program sent to you. It's important that moms-to-be make and keep appointments with their provider and ask questions about their care.

It's just as important to take care of yourself after you give birth. You should have a postpartum check-up 21 to 56 days after you deliver your baby. This exam is covered at no charge by Sanford Health Plan.

Use the website to support your health goals

You can complete an online health survey to get a personalized, "health report." It will give you goals that you can choose to work on to make you healthier. Visit www.sanfordhealthplan.com/memberlogin and sign-up to create your personalized account today!

How Sanford Health plan takes care of you

Sanford Health Plan's Medical Management staff wants to make sure you get the best care possible. Medical Management staff can help you make provider appointments or give prior-approval for hospital stays.

The information discussed with you or your provider is confidential. This program is free for you. Medical Management is open between the business hours of 8 a.m. to 5 p.m., Monday through Friday (excluding holidays), Central Time. Medical Management's toll-free number is (855) 276-7214. If you call after business hours, please leave a message and Sanford Health Plan will return your call within one business day.

Extra help when you have a chronic condition

If you have a chronic medical condition such as diabetes or heart disease, you'll be enrolled you in a disease management program. You'll get a booklet and newsletters to help you understand and manage your health. Please let Sanford Health Plan know if you need help understanding what is being sent to you.

If you have certain health conditions and meet medically frail eligibility criteria, you may be eligible for traditional Medicaid. For more information on this eligibility, please contact your local county social service office.

Extra help when you are sick

When you are seriously ill or injured, Sanford Health Plan provides the extra help and support you need through care management. You and your family will get the help you need to make good health care choices.

You'll be helped by case management nurses. Case managers are registered nurses who understand all parts of the health care system. Many have training in specific diseases and certification in case management. Your nurse works with you and your provider to coordinate your health care. Your nurse is a great resource when you have questions about your care.

Benefits for Members ages 19 and 20

Early	Assessing and identifying problems early
Periodic	Checking health at periodic, age-appropriate intervals
Screening	Providing physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems
Diagnostic	Performing diagnostic tests to follow up when a risk is identified, and
Treatment	Control, correct or reduce health problems found.

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit provides comprehensive and preventive health care services for Medicaid Expansion Members under age 21.

EPSDT is key to ensuring that Members ages 19 and 20 get appropriate preventive, dental, mental health, and developmental, and specialty services. This includes physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; treatment for vision, hearing and dental diseases and disorders, and much more.

My Sanford Nurse

My Sanford Nurse is a 24-hour phone line that can answer your health questions. You may call toll-free (888) 315-0886 to visit with a nurse or submit a question online through your mySanfordHealthPlan account at www.sanfordhealthplan.com/memberlogin.

Help giving up tobacco

If you use tobacco, our free tobacco cessation program can help. The program can help you whether you are thinking about quitting, are ready to quit or just want more information. Our program provides you with telephone support and resources to increase your chances for success. For more information or to enroll, call Medical Management's toll-free number at (855) 276-7214.

Smoking cessation medicines. You may get smoking cessation medicines and over-the-counter nicotine replacement patches at no charge. You must have a doctor's prescription for the drugs and patches to be covered.

How to read your Explanation of Benefits (EOB)

Each time you get health care, Sanford Health Plan sends you an Explanation of Benefits (also called an EOB). **When you get an EOB from Sanford Health Plan, remember that it is not a bill.** It shows how much was paid for your health care and how much you may owe to the provider (if you haven't already paid your copay).

How to read your EOB
(EOB=Explanation of Benefits)

This space is for important new messages – take the time to read!

Your benefit information at your fingertips, anytime, anywhere!

mySanfordHealthPlan, your personalized tool, found at www.sanfordhealthplan.com, allows you to:

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

Now available: mySanfordHealthPlan mobile app.

Explanation of Benefits – This is NOT a Bill

Member#: 11122233301		Member Name: Jane Doe				Provider: 1234567892, Provider John				
Claim#: 123456		Vendor: Sanford Clinic								
Service Date	*Description	Amount Billed	Discount Amount	Non-Covered Amount	Reason Codes	Allowed Amount	Copay	Deductible	Co-insurance	Amount Paid
↑	↑	↑	↑	↑	↑	↑	↑	↑	↑	↑
Date you got health care	The amount charged for the care	Charges not covered by Sanford Health Plan	Explains why a claim was paid or denied	The amount you owe to the provider	The amount Sanford Health Plan has paid to the provider for your					
The types of health care services you received	How much charges were reduced because you used a network provider	The amount Sanford Health Plan has agreed to pay the provider for your care		Does not apply to your plan	Does not apply to your plan					

09/24/2013	73	117.00	70.49	0.00		46.51	0.00	0.00	0.00	46.51
09/24/2013	73	117.00	70.49	0.00		46.51	0.00	0.00	0.00	46.51
09/24/2013	98	226.00	70.31	0.00		155.69	2.00	0.00	0.00	153.69
Totals		460.00	211.29	0.00		248.71	2.00	0.00	0.00	246.71

The total member responsibility for this claim is: \$2.00

*Description/Messages

73 DIAGNOSIS MEDICAL

98 PROFESSIONAL (PHYSICIAN) VISIT - OFFICE

*** For additional information about benefits, please refer to your plan booklet. For questions concerning the determination of your benefits, please contact Member Services at (855) 305-5060. If your claim was denied in whole or in part, you have the right to appeal by writing to Sanford Health Plan. Please submit your written appeal to: Sanford Health Plan PO Box 91110, Sioux Falls, SD 57109-1110. Appeals must be submitted within 30 days.

What to do if you have a concern

If you file a complaint

Sanford Health Plan and your provider want you to be satisfied with the services you get. If you have a problem relating to your care, you can call Member Services to complain. A complaint is a written or oral complaint that might include:

- The quality of care you got from your provider;
- How long it took to get a provider appointment;
- How long you had to wait to see the provider;
- A situation where you feel you feel your member rights were not followed; or
- Complaints about your benefits or Sanford Health Plan.

If your concern or complaint cannot be corrected by your provider or Sanford Health Plan, you may follow the complaint and appeals process below. Appeals generally relate to coverage for medical services. Complaints are usually about other aspects of your care or service.

If you aren't happy or have a complaint about Sanford Health Plan or your provider, you can call (855) 305-5060 or write:

Sanford Health Plan

Attn: Member Services

PO Box 91110

Sioux Falls, SD 57109-1110

Sanford Health Plan will keep your complaint private. You will be notified in writing when your complaint is received and the Plan will acknowledge any time you contact us about your complaint or appeal. Sanford Health Plan will respond in writing to your complaint within 90 calendar days of getting your complaint, or as soon as needed based on your health condition.

You can also file a complaint by calling Sanford Health Plan or by logging into your *mySanfordHealthPlan* account at

www.sanfordhealthplan.com/memberlogin.

If you have questions about the Sanford Health Plan Nondiscrimination Policy, please contact the nondiscrimination coordinator at (855) 305-5060 (*toll-free*) | TTY/TDD: (877) 652-1844 (*toll-free*). If you need help understanding this process and speak a language other than English, free oral interpretation is available for any language by calling toll-free 1-800-892-0675.

If you file an appeal

You can file an appeal when you disagree with a decision Sanford Health Plan has made. For example, you have the right to file an appeal if:

- Sanford Health Plan will not approve or limit the health care that you or your provider have requested;
- Sanford Health Plan reduces, suspends or terminates health care you have been receiving;
- Sanford Health Plan denies, in whole or in part, payment for a prior-approved or covered service; or
- You would like Sanford Health Plan to take action regarding a problem you are having with the plan.

There is a time limit on filing an appeal. You must file an appeal within **30** calendar days of the problem or denial. You can have someone else, such as a family member or a lawyer, appeal for you. You must put in writing that you want another person to appeal for you.

If you want to keep getting benefits during your appeal, you must contact us to appeal within 10 days of being denied a benefit or service. To start an appeal, call us or write a letter about the problem. If you call us, we will send you an appeal filing form that you must complete, or we will help you complete if you ask for help. Send your appeal to:

Sanford Health Plan
Attn: Member Services
PO Box 91110
Sioux Falls, SD 57109-1110

You can also call toll-free (855) 305-5060 and Sanford Health Plan will mail you an Appeal Form and a postage-paid return envelope. If you need help writing a letter, please call Member Services. Sanford Health Plan will send you a letter when your appeal is received.

A provider with a similar or the same specialty as your treating provider will review your appeal. This provider will not be the same person who made the original decision to deny, reduce or stop the medical service. If the final decision is not in your favor, you may have to pay for the services you received while your appeal was being reviewed.

There is a time limit for Sanford Health Plan to make a decision on your appeal. Sanford Health Plan will review your appeal and notify you of a decision within 45 calendar days of your request, or as soon as needed based on your health condition. Sanford Health Plan may take up to 14 business days more to make a decision if more information is needed from your provider. Sanford Health Plan will send you a letter if this happens.

State Fair Hearing Process

You have a right to request a fair hearing with the Department of Human Services. You can do this after Sanford Health Plan has made a decision on your appeal. You must send your request in writing within 30 days of Sanford Health Plan's decision. You may keep getting benefits during your appeal if you request a fair hearing within 10 days. If the final decision is not in your favor, you may have to pay for the services you received while your appeal was being reviewed.

To request a State Fair Hearing, send your request to Department of Human Services:

Appeals Supervisor, Legal Advisory Unit
ND 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
Email: dhs1au@nd.gov

If you need help filing your request, you can call Sanford Health Plan's Member Services toll-free at (855) 305-5060. When the Department of Human Services gets your request, they will send you an information packet. This will include the date and location of the hearing.

There is a time limit for the Department of Human Services to make a decision on your appeal. The State will review your request and notify you of a decision within 90 calendar days of your request. If your request was urgent and you had an expedited appeal, the State will review your request and notify you of a decision within 3 business days of your request.