Sanford Health Plan

http://www.sanfordhealthplan.com

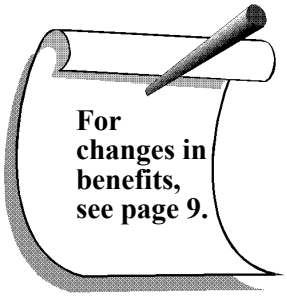
SANFORD HEALTH PLAN

2012

A Health Maintenance Organization and a point of service product

Serving: Central, Eastern South Dakota and the Rapid City area, and Northwestern Iowa

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 8 for requirements.



Sanford Health Plan's Commercial HMO product recieved NCQA's Commendable Accreditation Status.

Enrollment codes for this Plan:

- **AU1 High Option - Self Only**
- **AU2 High Option - Self and Family**
- **AU4 Standard Option - Self Only**
- **AU5 Standard Option - Self and Family**

Federal Employees Health Benefits Program

Authorized for distribution by the:

United States Office of Personnel Management

Healthcare and Insurance
http://www.opm.gov/insure

Important Notice from Sanford Health Plan About Our Prescription Drug Coverage and Medicare

OPM has determined that Sanford Health Plan's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage and go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage, your monthly premium will go up a least 1% per month for every month that you did not have that coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what many other people pay. You'll have to pay this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the Annual Coordinated Election Period (October 15th through December 7th) to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227) (TTY 1-877-486-2048).

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Introduction

This brochure describes the benefits of under our contract (CS 2843) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for administrative offices is:

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

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2012, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2012, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them easy to understand. Here are some examples,

- Except for necessary technical terms, we use common words. For instance, "you" means the enrollee or family member, "we" means Sanford Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans' brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM's "Rate Us" feedback area at www.opm.gov/insure or e-mail OPM at fehbwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management Healthcare and Insurance, Federal Employee Insurance Operations, Program Analysis and Systems Support, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM's Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Do not give your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.
- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:

- Call the provider and ask for an explanation. There may be an error.
- If the provider does not resolve the matter, call us at 800-752-5863 and explain the situation.
- If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
  - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise) or
  - Your child age 26 or over (unless he/she was disabled and incapable of self-support prior to age 26)
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- Fraud or intentional misrepresentation of material fact is prohibited under this Plan. You can be prosecuted for fraud and your agency may take action against you. Examples of fraud include, falsifying a claim to obtain FEHB benefits, trying to or obtaining services or coverage for yourself for someone who is not eligible for coverage, or enrolling in the Plan when you are no longer eligible.
- If your enrollment continues after you are no longer eligible for coverage (i.e., you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member is no longer eligible to use your health insurance coverage.

Preventing Medical Mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.

- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.
- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.
- Contact you doctor or parmacist if you have any questions.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
  - "Exactly what will you be doing?"
  - "About how long will it take?"
  - "What will happen after surgery"
  - "How can I expect to feel during recovery?"
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Patient Safety Links

- www.ahrq.gov/consumer/ The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.

Never Events

You will not be billed for inpatient services related to treatment of specific hospital acquired conditions or for inpatient services needed to correct never events, if you use participating providers. This policy helps to protect you from preventable medical errors and improve the quality of care you receive.

When you enter the hospital for treatment of one medical problem, you don't expect to leave with additional injuries, infections or other serious conditions that occur during the course of your stay. Although some of these complications may not be avoidable, too often patients suffer from injuries or illnesses that could have been prevented if the hospital had taken proper precautions.

We have a benefit payment policy that encourages hospitals to reduce the likelihood of hospital-acquired conditions such as certain infections, severe bedsores and fractures; and reduce medical errors that should never happen called "Never Events". When a Never Event occurs neither your FEHB plan nor you will incur cost to correct the medical error.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the Plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

This Plan's Standard option is a "grandfathered health plan" under the Affordable Care Act. A grandfathered plan must preserve basic health coverage that was already in effect when the law passed. Specifically, this plan cannot eliminate all or substantially all benefits to diagnose or treat a particular condition; it cannot increase your coinsurance (the percentage of a bill you pay); and any increases in deductibles, out-of-pocket limits, and other copayments (the fixed-dollar amount you pay) must be minimal.

This Plan's High option is a "non-grandfathered health plan" under the Affordable Care Act. A non-grandfathered plan must meet immediate health care reforms legislated by the Act. Specifically, this plan must provide preventive services and screenings to you without any cost sharing; you may choose any available primary care provider for adult and pediatric care; visits for obstetrical or gynecological care do not require a referral; and emergency services, both in- and out-of-network, are essentially treated the same (i.e., the same cost sharing, no greater limits or requirements for one over the other; and no prior authorizations).

Sanford Health Plan has decided to follow immediate reforms that apply to both grandfathered and non-grandfathered plans:

- 100% coverage (no cost sharing) of federally recommended preventive health services; and
- the right to designate any primary care provider who participates in our network. For children, you may designate a pediatrician as the primary care providers. For women, you do not need prior authorization from Sanford Health Plan or from any other person (including primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology.

Questions regarding what protections apply and what protections do not apply to a grandfathered health plan, and what might cause a plan to change status from grandfathered to non-grandfathered may be directed to us at memberservices@sanfordhealth.org. You can also read additional information from the U.S. Department of Health and Human Services at www.healthcare.gov.

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

We have Point of Service (POS) benefits

Our HMO offers Point of Service (POS) benefits. This means you can recieve covered services from a non-participating provider. However, Out-of-Network benefits may have higher out-of-pocket costs than our in-network benefits.

General features of our High and Standard Plan Options

Our HMO offers POS benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These Out-of-Network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- **Years in existence**
- **Profit status**

If you want more information about us, call 800-752-5863, or write to Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. You may also contact us by fax at 605-328-6812 or visit our website at www.sanfordhealthplan.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

In South Dakota our service area is: Aurora, Beadle, Bennett, Bon Homme, Brookings, Brown, Brule, Buffalo, Butte, Campbell, Charles Mix, Clark, Clay, Codington, Davison, Day , Deuel, Douglas, Edmunds, Faulk, Grant, Gregory, Hamlin, Hand, Hanson, Hughes, Hutchinson, Hyde, Jerauld, Kingsbury, Lake, Lawrence, Lincoln, Lyman, Marshall, McCook, McPherson, Meade, Miner, Minnehaha, Moody, Pennington, Potter, Roberts, Sanborn, Spink, Stanley, Sully, Todd, Tripp, Turner, Union, Walworht, and Yankton.

In Iowa our service area is: Clay, Dickinson, Emmet, Ida, Lyon, O'Brien, Ocseola, Plymouth, Sioux, and Woodbury.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we changed for 2012

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Program-wide changes

- Sections 3, 7, and 8 have changed to reflect claims processing and disputed claims requirements of the Patient Protection and Affordable Care Act, Public Law 111-148.

Changes to the High Option Only

- Your share of the non-postal premium will increase for Self only or for Self and Family. See page 80.

Changes to both High and Standard Options

- Your share of the non-postal premium will increase for Self only or for Self and Family. See page 80.
- The Plan is changing the age eligibility for the surgical treatment of morbid obesity from 21 years of age to 18. In addition, a BMI of 40 would be required for three consecutive years or a BMI greater than 35 for the last year in conjunction with severe comorbidities. See page 30.
- The Plan is including coverage under Organ/Tissue Transplants for autologous transplants for Waldenstrom's macroglobulinemia. See page 34.
- The Plan is also adding coverage under Organ/TissueTransplants for non-myeloablative allogeneic transplants for colon cancer. See page 36.

Section 3. How you get care

Identification cards

We 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 Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-752-5863 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.

Where you get covered care

You get care from "Plan providers" and "Plan facilities." You will only pay copayments, deductibles, and/or coinsurance. If you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member should choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a family practitioner, internist, pediatrician, general practitioner or OB/GYN. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. Appropriate access for Primary Care Physicians and Hospital Provider sites is within thirty (30) miles of your city of residence. Appropriate access includes access to our providers when you have traveled outside of the service area. If you are traveling within the service area where other Plan providers are available then you must use Plan providers

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician may refer you to a specialist for needed care. However, you may also self–refer to Plan specialist providers. No referral is necessary. Appropriate access for Specialty Physicians and Hospital Provider sites is within ninety (90) miles of your city of residence. Appropriate access includes access to Plan providers when you have traveled outside of the service area. If you are traveling within the service area where other Plan providers are available then you must use Plan providers.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, you may directly access the specialist for needed services.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we: you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.
  - terminate our contract with your specialist for other than cause;
  - drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
  - reduce our service area and you enroll in another FEHB Plan;
- If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

- **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our Member Service department immediately at (605) 328-6800 or 1-800-752-5863. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center;
- The day your benefits from your former plan run out;
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

- **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Service department immediately at (605) 328-6800 or 1-800-752-5863. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- you are discharged, not merely moved to an alternative care center;
- the day your benefits from your former plan run out; or
- the 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

You need prior Plan approval for certain services

You are ultimately responsible for obtaining Prior Approval from the Utilization Management Department in order to receive In-Network coverage. However, information provided by the provider's office will 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.

- **Inpatient hospital admission**

Precertification is the process by which – prior to your inpatient hospital admission – we evaluate the medical necessity of your proposed stay and the number of days required to treat your condition.

- **Other services**

For certain services, you must obtain prior approval from us. Before giving approval, we consider if the service is covered, medically necessary, and follows generally accepted medical practice. You must obtain prior authorization for:

- Inpatient hospital admissions including admissions for medical, surgical, neonatal intensive care nursery, mental health and chemical dependency services;
- Partial Hospital Program (PHP)/Day Treatment for mental health and chemical dependency services;
- Outpatient Surgeries;
- Covered dental procedures;
- Home Health, Hospice and Home IV therapy services;
- Some Durable Medical Equipment;
- One-to-one water therapy;
- Skilled nursing and sub-acute care;
- Transplant Services;
- PET Scans;
- Growth Hormone Therapy;
- Ambulance Services for non-emergency situations; and
- Referrals to Non-Participating Providers which are recommended by Participating Providers. Prior Approval is required for the purposes of receiving In-Network coverage for referrals to Non-Participating Providers which are recommended by Participating Providers. If Prior Approval is not obtained for referrals to Non-Participating Providers, the services will be covered at the Out-of-Network coverage level. Prior Approval does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers.

How to request precertification for an admission or get prior authorization for Other services

First, your physician, your hospital, you, or your representative, must call us at 1-800-805-7938 before admission or services requiring prior authorization are rendered.

Next, provide the following information:

- enrollee's name and Plan identification number;
- patient's name, birth date, identification number and phone number;
- reason for hospitalization, proposed treatment, or surgery;
- name and phone number of admitting physician;
- name of hospital or facility; and
- number of planned days of confinement.

- **Urgent care claims**

If you have an urgent care claim (i.e., when waiting for the regular time limit for your medical care or treatment could seriously jeopardize your life, health, or ability to regain maximum function, or in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without this care or treatment), we will expedite our review and notify you of our decision within 72 hours. If you request that we review your claim as an urgent care claim, we will review the documentation you provide and decide whether it is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you fail to provide sufficient information, we will contact you within 24 hours after we receive the claim to provide notice of the specific information we need to complete our review of the claim. We will allow you up to 48 hours from the receipt of this notice to provide the necessary information. We will make our decision on the claim within 48 hours of (1) the time we received the additional information or (2) the end of the time frame, whichever is earlier.

We may provide our decision orally within these time frames, but we will follow up with written or electronic notification within three days of oral notification.

- **Emergency inpatient admisson**

If you have an emergency admission due to a condition that you reasonably believe puts your life in danger or could cause serious damage to bodily function, you, your representative, the physician, or the hospital must telephone us within 2 business days following the day of the emergency admission, even if you have been discharged from the hospital.

- **Maternity care**

You do not need to precertify your normal delivery, however, you must notify the Plan of the date of scheduled C-sections when it is confirmed to precertify your inpatient stay. We also encourage you to participate in our *Healthy Pregnancy Program* by calling 1-800-752-5863 to enroll.

- **If your treatment needs to be extended**

If you request an extension of an ongoing course of treatment at least 24 hours prior to the expiration of the approved time period and this is also an urgent care claim, then we will make a decision within 24 hours after we receive the claim.

- **Non-urgent care claims**

For non-urgent care claims, we will then tell the physician and/or hospital the number of approved inpatient days, or the care that we approve for other services that must have prior authorization. We will make our decision within 15 days of receipt of the pre-service claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review and we will notify you of the need for an extension of time before the end of the original 15 day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

What happens when you do not follow the precertification rules when using non-network facilities

If Prior Approval is not obtained the services will be covered at the reduced benefit level.

Circumstances beyond our control

Under certain extraordinary circumstances, such as natural disasters, we may have to delay your services or we may be unable to provide them. In that case, we will make all reasonable efforts to provide you with the necessary care.

If you disagree with our pre-service claim decision

If you have a **pre-service claim** and you do not agree with our decision regarding precertification of an inpatient admission or prior approval of other services, you may request a review in accord with the procedures detailed below.

If you have already received the service, supply, or treatment, then you have a **post-service claim** and must to follow the entire disputed claims process detailed in Section 8.

- **To reconsider a non-urgent care claim**

Within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

In the case of a pre-service claim and subject to a request for additional information, we have 30 days from the date we receive your written request for reconsideration to

1. Precertify your hospital stay, or, if applicable, arrange for the health care provider to give you the care or grant your request for prior approval for a service, drug, or supply; or
2. Ask you or your provider for more information.

You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.

If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.

3. Write to you and maintain our denial.

- **To reconsider an urgent care claim**

In the case of an appeal of a pre-service urgent care claim, within 6 months of our initial decision, you may ask us in writing to reconsider our initial decision. Follow Step 1 of the disputed claims process detailed in Section 8 of this brochure.

Subject to a request for additional information, we will notify you of our decision within 72 hours after receipt of your reconsideration request. We will hasten the review process, which allows oral or written requests for appeals and the exchange of information by telephone, electronic mail, facsimile, or other expeditious methods.

- **To file an appeal with OPM**

After we reconsider your **pre-service claim**, if you do not agree with our decision, you may ask OPM to review it by following Step 3 of the disputed claims process detailed in Section 8 of this brochure.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments

A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: Under **High Option**, your office visit copayment per visit is $20 for primary care physicians and $30 for Specialist. Under **Standard Option**, office visit copayments are $25 per visit.

Deductible

A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them.

Example: Under **High Option**, deductibles only apply when you use our Point of Services (POS) benefits. There is a $500 deductible for Self enrollment and a $1,000 deductible for Self and Family enrollment. Under **Standard Option**, deductibles apply to both Participating providers and POS benefits. The deductible for Participating provider benefits is $500 Self enrollment and $1,000 Self and Family. The POS benefit deductible is $1,000 Self enrollment and $3,000 Self and Family.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance

Coinsurance is thepercentage of our negotiated fee that you must pay for certain in-network and all Out-of-Network care. Coinsurance doesn't begin until you meet your deductible (there is no deductible for in-network care under the High Option).

Example: Under **High Option,** you pay 40% of our allowance for medical office visits when you receive services from a Non-Participating Provider or you pay 20% of our negotiated fee for durable medical equipment and orthopedic appliances received by in-network providers. Under **Standard Option,** you pay 20% of our allowance for outpatient surgery when you receive services from Participating Providers or you pay 40% of our allowance for medical office visits when you receive services from non-Participating Providers with POS benefits.

Your catastrophic protection out-of-pocket maximum

Under the **High Option,** after your in-network copayments total $4,000 Self enrollment or $4,000 Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. Under the **Standard Option**, after your in-network copayments and coinsurances total $3,000 Self enrollment or $4,000 Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs; and
- Physician office visits.

Be sure to keep accurate records of your copayments, deductibles and coinsurance since you are responsible for informing us when you reach the maximum.

When Government Facilities Bill Us

Facilities of the Department Government Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from for certain services and supplies they provide to you or a family member. They may not seek more than the governing laws allow. You may be responsible to pay for certain services and charges. Contact the government facility directly for more information.

Section 5. High and Standard Option Benefits

See page 9 for how our benefits changed this year. Page 70 and page 72 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Section 5. High and Standard Option Benefits Overview

This plan offers both a High and Standard Option. Our benefit package is described in Section 5. Make sure that you review the benefits carefully.

The High and Standard Option Section 5 is divided into subsections. Please read the *Important things you should keep in mind* at the beginning of the subsections. Also, read the General Exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-752-5863 or at our website, www.sanfordhealthplan.com .

High Option	No in-network deductible. Office visit copay of $20 for a primary care visit (PCP) and $30 for a specialty care visit. There is a $4,000 out-of-pocket maximum for self only and $4,000 for self and family enrollment per year.
Standard Option	In-network deductible is $500 for self only and $1,000 for self and family enrollment per year. Office copay of $25 for both primary care and specialty care visits. There is a 20% in-network coinsurance for family planning and infertility services, treatment therapies, physical, cardiac, speech, and occupational therapies, orthopedic and prothestic devices, home health services, acupuncture, outpatient surgical procedures, anesthesia, skilled nursing care, and ambulance services. There is a $3,000 out-of-pocket maximum for self only and $4,000 for self and family enrollment per year.

Section 5(a). Medical services and supplies provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option,** we have no calendar year deductible for In Network services.
- **Under Standard Option,** the calendar year deductible for In Network services is $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under both High and Standard Options,** you must use Plan Providers in order to receive In Network benefit coverage.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also, read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
Diagnostic and treatment services	**High Option**	**Standard Option**
Professional services of physicians, nurse practitioners, and physician's assistants • In physician's office • Office medical consultations • Second surgical opinion	$20 copay per primary care visit $30 copay per specialist visit	$25 copay primary or specialist per visit (No deductible)
• In an urgent care center	$20 copay per visit	$25 copay per visit
• During a hospital stay • In a skilled nursing facility • Home visits	Nothing	Nothing
Lab, X-ray and other diagnostic tests	**High Option**	**Standard Option**
Tests, such as: • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG • PET Scans (See *Services requiring our prior approval)*	Nothing if you receive these services during your office visit	20% of charges
Not covered: Virtual colonoscopies	*All charges*	*All charges*

Benefit Description	You pay	
Preventive care, adult	**High Option**	**Standard Option**
Routine physical annually which includes: Routine screenings, such as: • Total Blood Cholesterol Colorectal Cancer Screening , including • Fecal occult blood test • Sigmoidoscopy, screening – every five years starting at age 50 • Double contrast barium enema – every five years starting at age 50 • Colonoscopy screening – every ten years starting at age 50	Nothing	Nothing (No deductible)
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	Nothing (No deductible)
Routine Pap test	Nothing	Nothing (No deductible)
Routine mammogram - covered for women age 40 and older, as follows: • Once every calendar year	Nothing	Nothing (No deductible)
• Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing	Nothing (No deductible)
Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.	*All charges*	*All charges*
Preventive care, children	**High Option**	**Standard Option**
• Childhood immunizations recommended by the American Academy of Pediatrics	Nothing	Nothing (No deductible)
• Well-child care charges for routine examinations, immunizations and care (up to age 22) • Examinations, such as: - Eye exams through age 17 to determine the need for vision correction - Hearing exams through age 17 to determine the need for hearing correction - Examinations done on the day of immunizations (up to age 22)	Nothing	Nothing (No deductible)

Benefit Description	You pay	
Maternity care	**High Option**	**Standard Option**
Complete maternity (obstetrical) care, such as: • Prenatal care • Delivery • Postnatal care Note: Here are some things to keep in mind: • You do not need to precertify your normal delivery; however, we encourage you to participate in our Healthy Pregnancy Program; see *Special Features Section.* • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits apply to circumcision. Note: Adopted newborns' delivery and nursery charges are covered upon commencement of the legal adoption bonding period. • We cover up to 2 routine sonograms per pregnancy to determine fetal age, size or sex. • We pay hospitalization and surgeon services for non-maternity care the same as for illness and injury.	Nothing	Nothing
Family planning	**High Option**	**Standard Option**
A range of voluntary family planning services, limited to: • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms Note: We cover oral contraceptives under the prescription drug benefit.	$20 copay per primary care visit $30 copay per specialist visit 20% of charges per inpatient admission $50 per outpatient surgery	20% of charges
Voluntary Sterilization Note: We pay voluntary sterilization performed secondary to a Cesarean section under See Section 5 (b), *Surgical procedures.*	20% of charges per inpatient admission	20% of charges

Family planning - continued on next page

Benefit Description	You pay	
Family planning (cont.)	**High Option**	**Standard Option**
Not covered: • *Reversal of voluntary surgical sterilization* • *Genetic counseling*	*All charges*	*All charges*
Infertility services	**High Option**	**Standard Option**
Diagnosis and treatment of infertility such as: • Artificial insemination: - Intravaginal insemination (IVI) - Intracervical insemination (ICI) - Intrauterine insemination (IUI)	$30 per specialist visit 20% of charges per inpatient admission $50 per outpatient surgery	20% of charges
Not covered: *Assisted reproductive technology (ART) procedures, such as:* • *In vitro fertilization* • *Embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)* • *Services and supplies related to ART procedures* • *Cost of donor sperm* • *Cost of donor egg* • *Fertility drugs* • *Expenses related to surrogate parenting* • *Other preservation techniques*	*All charges*	*All charges*
Allergy care	**High Option**	**Standard Option**
• Testing and treatment • Allergy injections	$30 per specialist visit	$25 copay per visit (No deductible)
Allergy Serum	Nothing	Nothing
Not covered: • *Provocative food testing* • *Sublingual allergy desensitization*	*All charges*	*All charges*
Treatment therapies	**High Option**	**Standard Option**
• Chemotherapy and radiation therapy Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under *Organ/Tissue Transplants in Section 5(b).* • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT)	$30 per specialist visit	20% of charges

Treatment therapies - continued on next page

Benefit Description	You pay	
Treatment therapies (cont.)	**High Option**	**Standard Option**
Note: Growth hormone is covered under the medical benefit. Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment. We will only cover GHT services and related services and supplies that we determine are medically necessary. See *Services requiring our prior approval* in Section 3.	$30 per specialist visit	20% of charges
Physical and occupational therapies	**High Option**	**Standard Option**
Coverage up to 2 consecutive months per condition for the services of each of the following: • Qualified Physical Therapists • Occupational Therapists Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury (see *Services requiring our Prior Approval in Section 3*). • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction	$30 per outpatient visit Nothing per visit during covered inpatient admission	20% of charges
Not covered: • *Long-term rehabilitative therapy* • *Exercise programs*	*All charges*	*All charges*
Speech therapy	**High Option**	**Standard Option**
Coverage up to 2 consecutive months per condition by speech therapists (see *Services requiring our Prior Approval* in Section 3).	$30 per outpatient visit Nothing per visit during covered inpatient admission	20% of charges
Hearing services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• For treatment related to illness or injury, including evaluation and diagnostic hearing tests performed by an M.D., D.O., or audiologist Note: For routine hearing screening performed during a child's preventive care visit, see Section 5(a) *Preventive care, children.*	$30 per specialist visit	$25 copay per visit (No deductible)
• External hearing aids • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants Note: For benefits for the devices, see Section 5(a) *Orthopedic and prosthetic devices.*	20% of charges	20% of charges

Hearing services (testing, treatment, and supplies) - continued on next page

Benefit Description	You pay	
Hearing services (testing, treatment, and supplies) (cont.)	**High Option**	**Standard Option**
Not covered: • *Hearing services that are not shown as covered*	*All charges*	*All charges*
Vision services (testing, treatment, and supplies)	**High Option**	**Standard Option**
• One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts)	$20 per primary care visit $30 per specialist visit	$25 copay per visit (No deductible)
• Annual eye exam including refraction error to determine the need for vision correction for children through age 17(See *Preventive care, children)*	Nothing	Nothing (No deductible)
Not covered: • *Eyeglasses or contact lenses, except as shown above* • *Surgery for the purpose of modifying or correcting myopia, hyperopia or stigmatic error* • *All other vision services except as described above*	*All charges*	*All charges*
Foot care	**High Option**	**Standard Option**
Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes. Note: See *Orthopedic and prosthetic devices* for information on podiatric shoe inserts.	$20 per primary care visit $30 per specialist	$25 copay per visit (No deductible)
Not covered: • *Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above* • *Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)*	*All charges*	*All charges*
Orthopedic and prosthetic devices	**High Option**	**Standard Option**
• 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 *two (2)* additional pairs of inserts • Artificial limbs and eyes • Stump hose	20% of charges	20% of charges

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
Orthopedic and prosthetic devices (cont.)	**High Option**	**Standard Option**
• Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Includes 2 external prosthesis per calendar year and 2 bras per calendar year. For double mastectomy, coverage extends to 4 external prosthesis per calendar year and 2 bras per calendar year. • External hearing aid(s) • Implanted hearing-related devices, such as bone anchored hearing aids (BAHA) and cochlear implants • Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. • Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. (See *Services requiring our prior approval* in Section 3.) Note: For information on the professional charges for the surgery to insert an implant, see Section 5(b) Surgical procedures. For information on the hospital and/or ambulatory surgery center benefits, see Section 5(c) Services provided by a hospital or other facility, and ambulance services.	20% of charges	20% of charges
Not covered: • *Orthopedic and corrective shoes, arch supports, foot orthotics, heel pads and heel cups (except as covered under the diabetic benefit)* • *Lumbosacral supports* • *Corsets, trusses, elastic stockings, support hose, and other supportive devices* • *Prosthetic replacements provided prior to expiration of the manufacturers life expectancy of the prosthetic. Policy guidelines apply.* • *Dental appliances of any sort, including but not limited to bridges, braces, and retainers, except those for non-dental treatment of TMJ* • *Wigs, scalp hair prosthesis or hair transplants* • *Cleaning and polishing of prosthetic eye(s)*	*All charges*	*All charges*

Benefit Description	You pay	
Durable medical equipment (DME)	**High Option**	**Standard Option**
Rental or purchase, at our option, including repairs (repairs are limited to $750 allowable charges per year) and adjustments, of durable medical equipment prescribed by your Plan physician. Under this benefit, we also cover: • Oxygen • Dialysis equipment • Standard hospital beds • Standard wheelchairs • Crutches • Walkers • Canes • Diabetes supplies including blood glucose monitors and insulin pumps • Spacers • Initial casts, braces, and/or slings provided on day of treatment • Air compressor • Pressure pads, mattresses, and decubitus care equipment • Apnea monitor • Sleeve compression • Home intravenous therapy supplies • Commodes • Compression hose Note: We will cover motorized wheelchairs and electric beds up to, but not to exceed, the cost of standard wheelchairs or standard hospital beds. Limited to one per lifetime. Call us at (605) 328-6807 or toll free at 1-800-805-7938 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.	20% of charges Note: You must obtain prior-authorization for the following supplies/equipment. Failure to obtain Prior Approval will result in benefits being paid at the Point of Service benefit level.	20% of charges Note: You must obtain prior-authorization for the following supplies/equipment. Failure to obtain Prior Approval will result in benefits being paid at the Point of Service benefit level.
Not covered: • *Medical supplies/equipment that can be purchased over-the-counter* • *Household equipment/fixtures, such as air purifiers and ramps* • *Convenience items* • *Self-help items* • *Educational equipment*	*All charges*	*All charges*

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	**High Option**	**Standard Option**
• *Communication aids or devices such as speech processors, receivers, communication boards, or computer or electronic assisted communication* • *Replacement or repair of items, if the items are damaged or destroyed by your misuse, abuse or carelessness, lost, or stolen* • *Duplicate or similar items* • *Service call charges, labor charges, charges for repair estimates* • *Vehicle/car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier*	*All charges*	*All charges*
Home health services	**High Option**	**Standard Option**
• Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. • Services include oxygen therapy, intravenous therapy and medications. Note: One home health visit constitutes 4 hours of nursing care. Prior approval is required; failure to get prior approval will result in payment at the point of service level (See *Services requiring our prior approval* in Section 3).	$20 copay per visit	20% of charges
Not covered: • *Nursing care requested by, or for the convenience of, the patient or the patient's family* • *Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative*	*All charges*	*All charges*
Chiropractic	**High Option**	**Standard Option**
• Manipulation of the spine and extremities • Adjunctive procedures such as ultrasound, electrical muscle stimulation, and vibratory therapy Note: Office visits are limited to 20 visits per calendar year.	$20 copay per visit	$25 copay per visit (No deductible)
Not covered: • *Vitamins, minerals, therabands, cervical pillows, traction services, and hot/cold pack application.*	*All charges*	*All charges*

Benefit Description	You pay	
Alternative treatments	**High Option**	**Standard Option**
Acupuncture – by a doctor of medicine or osteopathy for: • anesthesia • pain relief Sleep therapy for central of obstructive apnea when we have approved it	$30 per specialist visit	20% of charges
Not covered: • *Homeopathic or Naturopathic services* • *Hypnotherapy* • *Biofeedback*	*All charges*	*All charges*
Educational classes and programs	**High Option**	**Standard Option**
Coverage is provided for: • Tobacco cessation programs, including: Individual/group/telephone counseling, 2 quit attempts per year with up to 4 smoking cessation counseling sessions per quit attempt; approved smoking cessation prescription drugs approved by the FDA to treat tobacco dependence (see *Prescription drug benefits*) • Childhood obesity education • Diabetes self management training from qualified providers for persons who meet plan criteria - limited to no more than 2 comprehensive education programs per lifetime and up to 8 follow-up visits per year will be covered.	Nothing	Nothing (No deductible)

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option,** we have no calendar year deductible for In Network services.
- **Under Standard Option** The calendar year deductible is: $500 per person ($1000 per family). The calendar year deductible applies to almost all benefits in this Section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under both High and Standard Options,** you must use Plan Providers in order to receive in-network benefit coverage.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU OR YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR SOME SURGICAL PROCEDURES**. Please refer to the prior approval information shown in Section 3 to be sure which services require prior approval and identify which surgeries require precertification.

Benefit Description	You pay	
Surgical procedures	**High Option**	**Standard Option**
A comprehensive range of services, such as: • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see *Reconstructive surgery*) • Surgical treatment of morbid obesity (bariatric surgery). You must meet the following criteria before the surgery can be authorized: - Psychiatrist or Psychologist psychiatric evaluation prior to medical review - Body Mass Index (BMI) greater than 40 for three (3) consecutive years or a BMI greater than 35 for the last year in conjunction with severe comorbidities - Have tried other weight loss options for a two (2) year period without success - Age eighteen (18)	$30 per specialist visit	$25 copay per office visit (No deductible)

Surgical procedures - continued on next page

Benefit Description	You pay	
Surgical procedures (cont.)	**High Option**	**Standard Option**
Note: Contact the Utilization Management Department for additional information at (605) 328-6807 or 1-800-805-7938. • Insertion of internal prosthetic devices. See 5(a) – *Orthopedic and prosthetic devices* for device coverage information Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker. • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns	$30 per specialist visit	$25 copay per office visit (No deductible)
Not covered: • *Reversal of voluntary sterilization*	*All charges*	*All charges*
Reconstructive surgery	**High Option**	**Standard Option**
• Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities, cleft lip, cleft palate, birth marks, and webbed fingers and toes • All stages of breast reconstruction surgery following a mastectomy, such as: - surgery to produce a symmetrical appearance of breasts - treatment of any physical complications such as lymphedemas - breast prostheses and surgical bras and replacements (see Prosthetic devices) 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.	$30 per specialist visit	$25 copay per office visit (No deductible)

Reconstructive surgery - continued on next page

Benefit Description	You pay	
Reconstructive surgery (cont.)	**High Option**	**Standard Option**
Not covered: • *Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, including skin tag removal, except repair of accidental injury* • *Surgeries related to sex transformation*	*All charges*	*All charges*
Oral and maxillofacial surgery	**High Option**	**Standard Option**
Oral surgical procedures, limited to: • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Other surgical procedures that do not involve the teeth or their supporting structures; and • Surgery to correct TMJ is covered upon radiological determination of pathology (See *Services requiring our prior approval* in Section 3*)*	$30 per specialist visit	$25 copay per visit (No deductible)
Not covered: • *Oral implants and transplants* • *Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)*	*All charges*	*All charges*
Organ/tissue transplants	**High Option**	**Standard Option**
These **solid organ transplants** are covered subject to medical necessity and experimental/investigational review by the Plan. Refer to *Other services* in Section 3 for prior authorization procedures. • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Liver • Intestinal transplants - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas • Lung: single/bilateral	Nothing	Nothing

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Pancreas • Autologous pancreas islet cell transplant (as an adjunct to total or near total pancreatectomy) only for patients with chronic pancreatitis	Nothing	Nothing
These **tandem blood** or **marrow stem cell transplants for covered transplants** are subject to medical necessity review by the Plan. Refer to *Other services* in Section 3 for prior authorization review. • Autologous tandem transplants for - AL Amyloidosis - Multiple myeloma (de novo and treated) - Recurrent germ cell tumors (including testicular cancer)	Nothing	20% of charges
These **blood** or **marrow stem cell transplants for covered transplants** are limited to the stages of the following diagnoses. For the diagnoses listed below, the medical necesstiy limitation is considered satisfied if the patient meets the staging description. Physicians consider many features to determine how diseases will respond to different types of treatment. Some of the features measured are the presence or absence of normal and abnormal chromosomes, the extension of the disease throughout the body, and how fast the tumor cells can grow. By analyzing these and other characteristics, physicians can determine which diseases may respond to treatment without transplant and which diseases may respond to transplant. Allogenic transplants for: • Acute lymphocytic or non-lymphocytic (i.e., myelogeneous) leukemia • Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) • Burkitt's lymphoma for adolescents and young adults • Advanced Hodgkin's lymphoma with reoccurance (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurance (relapsed) • Infantile malignant osteopetrosis • Kostmann's syndrome • Leukocyte adhesion deficiencies • Marrow Failure and Related Disorders (i.e. Fanconi's PNH, pure red cell aplasia)	Nothing	20% of charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
• Mucolipidosis (e.g., Gaucher's disease, metachromatic leukodystrophy, adrenoleukodystrophy) • Mucopolysaccharidosis (e.g., Hunter's syndrome, Hurler's syndrome, Sanfilippo's syndrome, Maroteaux-Lamy syndrome variants) • Chronic myelogenous leukemia • Hemoglobinopathy • Myelodysplasia/Myelodysplastic syndromes • Severe combined immunodeficiency • Severe or very severe aplastic anemia • Amyloidosis • Paroxymal Nocturnal Hemoglobinuria • Acute myloid leukemia • Advanced Myeloporliferative Disorders (MPDs) • Advanced neuroblastoma • Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiscott-Aldrich syndrome) • Sickle cell anemia • X-linked lymphoproliferative syndrome Autologous transplant for: • Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia • Advanced Hodgkin's lymphoma with reoccurance (relapsed) • Advanced non-Hodgkin's lymphoma with reoccurance (relapsed) • Neuroblastoma • Amyloidosis • Multiple myeloma • Testicular, Mediastinal, Retroperitoneal, and ovarian germ cell tumors • Breast cancer • Epithelial ovarian cancer • Ependymoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma • Waldenstrom's macroglobulinemia	Nothing	20% of charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
Mini-transplants performed in a clinical trial setting (non-myeloablative, reduced intensity conditioning or RIC) for members with a diagnosis listed below are subject to medical necessity review by the Plan. Refer to *Other Services* in Section 3 for prior authorization procedures. • Allogenic transplants for: - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurence (relapsed) - Acute myeloid leukemia - Advanced Myeloproliferative Disorders (MPDs) - Amyloidosis - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Hemoglobinopathy - Marrow failure and related disorders (i.e. Fanconi's, PNH, Pure Red Cell Aplasia) - Myelodysplasia/Myelodyspalstic syndromes - Paroxysmal Nocturnal Hemoglobinuria - Severe combined immunodeficiency - Severe or very severe aplastic anemia • Autologous transplants for: - Acute lymphocytic or non-lymphocytic (i.e. myelogenous) leukemia - Advanced Hodgkin's lymphoma with reoccurence (relapsed) - Advanced non-Hodgkin's lymphoma with reoccurence (relapsed) - Anyloidosis - Neuroblastoma	Nothing	20% of charges
These blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial or a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols.	Nothing	20% of charges

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
If you are a participant in a clinical trial, the Plan will provide benefits for related routine care that is medically necessary (such as doctor visits, lab tests, x-rays and scans, and hospitalization related to treating the patients condition) if it is not provided by the clinical trial. Section 9 has additional information on costs related to clinical trials. We encourage you to contact the Plan to discuss specific services if you participate in a clinical trial.	Nothing	20% of charges
• Allogeneic transplants for - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Beta Thalassemia Major - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Sickle Cell anemia • Mini-transplants (non-myeloablative allogeneic, reduced intensity conditioning or RIC) for - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Multiple myeloma - Myeloproliferative disorders (MSDs - Sickle cell anemia • Autologous Transplants for - Advanced Childhood Kidney cancers - Advanced Ewing sarcoma - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Breast Cancer - Childhood rhabdomyosarcoma - Chronic myelogenous leukemia - Colon cancer - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma		

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	**High Option**	**Standard Option**
- Epithelial Ovarian Cancer - Mantle Cell (Non-Hodgkin lymphoma) • National Transplant Program (NTP) Note: We cover related medical and hospital expenses of the donor when we cover the recipient. We cover donor testing for the actual solid organ donor or up to four bone marrow/stem cell transplant donors in addition to the testing of family members. All transplants must be provided at Plan participating Center of Excellence facilities.	Nothing	20% of charges
Not covered: • *Harvesting and storage of stem cells* • *Implants of artificial organs* • *Transplants not listed as covered* • *Transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria*	*All charges*	*All charges*
Anesthesia	**High Option**	**Standard Option**
Professional services provided in – • Hospital (inpatient)	Nothing	20% of charges
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	20% of charges
Not covered: Hypnotic anesthesia	*All charges*	*All charges*

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- **Under High Option,** we have no calendar year deductible for In-Network services.
- **Under Standard Option,** the calendar year deductible for Participating Providers is $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under both High and Standard Options,** you must use Plan Providers in order to receive in-network benefit coverage.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i. e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior approval.

Benefit Description	You pay	
Inpatient hospital	**High Option**	**Standard Option**
Room and board, such as • Ward, semiprivate, or intensive care accommodations • General nursing care • Meals and special diets Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	$100 per day copay up to $500 per admission	$100 per day copay up to $500 per admission
Other hospital services and supplies, such as: • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood or blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipement and any covered items billed by a hospital for use at home or take home items	Nothing	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay	
Inpatient hospital (cont.)	**High Option**	**Standard Option**
Not covered: • *Custodial care* • *Non-covered facilities, such as nursing homes, schools* • *Personal comfort items, such as telephone, television, barber services, guest meals and beds* • *Private nursing care* • *Admissions to hospitals performed only for the convenience of the member, the member's family or the member's physician or other provider*	*All charges*	*All charges*
Outpatient hospital or ambulatory surgical center	**High Option**	**Standard Option**
• Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.	$50 per visit	20% of charges
Outpatient hospital services: • Diagnostic laboratory tests, X-rays and pathology services • Pre-surgical testing	Nothing	20% of charges
Not covered: Blood storage for use at a later date	*All charges*	*All charges*
Extended care benefits/Skilled nursing care facility benefits	**High Option**	**Standard Option**
Extended care benefit includes all necessary services ordered by a Plan provider including: • Unlimited days • Bed, board, and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a plan provider	$100 per day copay up to $500 per admission	$100 per day copay up to $500 per admission

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits (cont.)	**High Option**	**Standard Option**
Note: Care must be recieved from a state licensed nursing facility	$100 per day copay up to $500 per admission	$100 per day copay up to $500 per admission
Not covered: • *Custodial care* • *Convalescent care* • *Intermediate level or domiciliary care* • *Residential care* • *Rest cures or services to assist in activities of daily living*	*All charges*	*All charges*
Hospice care	**High Option**	**Standard Option**
• 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 • Part-time or intermittent nursing care by an RN, LPN, LVN or home health aide for patient care for up to 8 hours a day • Social services • Psychological and dietary counseling • Physical or occupational therapy • Consultation and case management services by a participating practitioner • Medical supplies and drugs prescribed by a participating practitioner	Nothing	20% of charges
Not covered: Independent nursing, homemaker services	*All charges*	*All charges*
Ambulance	**High Option**	**Standard Option**
Local professional ground and/or air ambulance service when medically appropriate and plan approved hospital transfers.	$50 copay	20% of charges
Not covered: • *Transfers to hospitals performed only for the convenience of the member, the member's family or the member's physician or other provider.* • *Non-emergency services and/or travel, unless pre-approved and arranged by us.*	*All charges*	*All charges*

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option,** we have no calendar year deductible for In Network services.
- **Under Standard Option,** the calendar year deductible for Participating Providers is $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under both High and Standard Options,** you must use Plan Providers in order to receive in-network benefit coverage.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency? A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency: In the event of an Emergency Medical Condition, go to the closest emergency room, or call 911 for assistance. We will cover Emergency Services whether you are in or out of the Service Area. Sioux Valley Health Plan offers world-wide emergency coverage. Prior approval for treatment of Emergency Medical Conditions is not required. You should have someone telephone us at 1-800-805-7938 as soon as reasonably possible. **Inpatient or outpatient emergency services that are furnished by any qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition are covered.**

Emergencies within our service area: If you have an Emergency Medical Condition within the Service Area, you should contact your PCP and the Plan after an emergency so that we can arrange for your follow-up care.

Emergencies outside our service area: If you have an Emergency Medical Condition while out of the Service Area, we prefer that you return to the Service Area to receive care through Plan Participating Providers after you have been treated for your condition. However, services will be covered out of the Service Area as long as the care required continues to meet the definition for either Emergency Services or Urgently Needed Services.

Whether you are inside or outside of our service area, $100 copay for Emergency or Urgent services applies. However, this copay is waived if you are admitted to a hospital as a result of the emergency visit.

Post-Stabilization Care: We also provide coverage for services needed to ensure that you remain stabilized (or, in certain instances, to improve or resolve your condition) if:

- We provide prior approval for such services; or
- The services were not pre-approved by us, but were administered within 1 hour of a request from the Provider for prior approval of additional post-stabilization care; or
- We do not respond within one (1) hour to a request for prior approval from a Non-Contracting Medical Provider or Facility (or we could not be contacted for prior approval).

Coverage for Post-Stabilization Care is effective until:

- You are discharged; or
- A Contracting Medical Provider with privileges at the hospital in which you are treated arrives and assumes responsibility for your care; or

- The Non-Contracting Medical Provider and Sanford Health Plan agree to other arrangements; or
- A Contracting Medical Provider assumes responsibility for your care through transfer.

Remember, if you receive services from Non-Contracting Medical Providers without Prior approval, except for Emergency Services, Urgently Needed Services, or out-of-area renal dialysis, Sanford Health Plan will pay for those services at the Out-of-Network benefit level.

Refunds for Emergency, Urgently Needed, or Out-of-Area Dialysis Services Paid by Members: Providers should submit bills to us for payment. However, if you paid for any Emergency Services, Urgently Needed Services, or Out-of-Area Renal Dialysis services obtained from Non-Contracting Medical Providers, you should submit your bills us to Sanford Health Plan for payment. Bills should be submitted to the following address:

Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. If you have questions about any bills, contact our Member Service Department at 1-800-752-5863 or (605) 328-6800. The hours of operation for these numbers are 8:00am until 5:00pm Central Standard Time, Monday through Friday.

Benefit Description	You pay	
Emergency within our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$20 per primary care visit $30 per specialist visit	$25 copay per primary care or specialist visit (No deductible)
• Emergency care as an outpatient at a hospital, including doctor's services Note: We waive the ER copay if you are admitted to the hospital. However, the inpatient admission copay still applies.	$100 copay per visit, waived if admitted	$100 copay per visit, waived if admitted (No deductible)
Not covered: Elective care or non-emergency care	*All charges*	*All charges*
Emergency outside our service area	**High Option**	**Standard Option**
• Emergency care at a doctor's office • Emergency care at an urgent care center	$20 per primary care visit $30 per specialist visit	$25 copay per primary care or specialist visit (No deductible)
• Emergency care as an outpatient at a hospital, including doctors' services Note: We waive the ER copay if you are admitted to the hospital. However, the inpatient admission copay still applies.	$100 per visit, waived if admitted	$100 per visit, waived if admitted (No deductible)
Not covered: • *Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers* • *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*	*All charges*	*All charges*

Benefit Description	You pay	
Ambulance	**High Option**	**Standard Option**
Professional ground ambulance, air ambulance, or regularly scheduled flight on a commercial airline when service is medically appropriate. Note: See 5(c) for non-emergency service.	$50 copay	20% of charges

Section 5(e). Mental health and substance abuse benefits

You need to get Plan approval (preauthorization) for services and follow a treatment plan we approve in order to get benefits. When you receive services as part of an approved treatment plan, cost-sharing and limitations for Plan mental health and substance abuse benefits are no greater than for similar benefits for other illnesses and conditions.

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option,** we have no calendar year deductible for In-Network services.
- **Under Standard Option,** the calendar year deductible for Participating Providers is $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR APPROVAL FOR THESE SERVICES.** Benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure. To be eligible to receive full benefits, you must follow the preauthorization process and get Plan approval of your treatment plan. For approval contact our Utilization Management Department at our toll-free number 1-800-805-7938 or (605) 328-6807, available Monday through Friday, between 8:00am and 5:00pm Central Time. After hours you may leave a message on the confidential voice mail of the Utilization Management Department and someone will return your call. Failure to obtain prior approval will result in a reduction to the Out-of-Network benefits level. However, information provided by the physician's office also satisfies this requirement.
- We will provide medical review criteria or reasons for treatment plan denials to enrollees, members or providers upon request or as otherwise required.
- OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.

Benefit Description	You pay	
Professional services	**High Option**	**Standard Option**
We cover professional services by licensed professional mental health and substance abuse practitioners when acting within the scope of their license, such as psychiatrists, psychologists, clinical social workers and licensed professional counselors.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.	Your cost-sharing responsibilities are no greater than for other illnesses or conditions.
Diagnosis and treatment of psychiatric conditions, mental illness, or mental disorders. Services include: • Diagnostic evaluation • Crisis intervention and stabilization for acute episodes • Medication evaluation and management (pharmacotherapy)	$20 per specialist outpatient visit	$25 per visit (No deductible)

Professional services - continued on next page

Benefit Description	You pay	
Professional services (cont.)	**High Option**	**Standard Option**
• Psychological and neuropsychological testing necessary to determine the appropriate psychiatric treatment • Treatment and counseling (including individual or program-based group therapy visits) • Diagnosis and treatment of alcoholism and drug abuse • Professional charges for intensive outpatient treatment in a provider's office or other professional setting	$20 per specialist outpatient visit	$25 per visit (No deductible)
Diagnostics	**High Option**	**Standard Option**
• Outpatient diagnostic tests provided and billed by a licensed mental health and substance abuse practitioner • Outpatient diagnostic tests provided and billed by a laboratory, hospital or other covered facility	Nothing	20% of charges
• Inpatient diagnostic tests provided and billed by a hospital or other covered facility	Nothing	Nothing
Inpatient hospital or other covered facility	**High Option**	**Standard Option**
Inpatient services provided and billed by a hospital or other covered facility • Room and board, such as semiprivate or intensive accommodations, general nursing care, meals and special diets, and other hospital services	$100 per day copy up to $500 per inpatient admission	$100 per day copy up to $500 per inpatient admission
Outpatient hospital or other covered facility	**High Option**	**Standard Option**
Outpatient services provided and billed by a hospital or other covered facility • Services in approved alternative care settings such as partial hospitalization, full-day hospitalization or facility-based intensive outpatient treatment	$100 per day copy up to $500 per inpatient admission	$100 per day copy up to $500 per inpatient admission
Not covered	**High Option**	**Standard Option**
• *Marriage, family, or bereavement counseling* • *Pastoral counseling* • *Financial or legal counseling* • *Custodial care counseling* • *Services we have not approved* • *Long term custodial care*	*All charges*	*All charges*

Preauthorization	To be eligible to receive these benefits you must obtain a treatment plan and follow all of the following network authorization processes: For the prior approval process for elective inpatient hospitalizations, non-urgent care, pharmaceutical decisions, behavioral health, urgent/emergency conditions, concurrent review and retrospective review (post-service) contact our Utilization Management Department, available between the hours of 8:00am and 5:00pm Central Time, Monday through Friday, by calling our toll-free number 1-800-805-7938 or (605) 328-6807. After hours you may leave a message on the confidential voice mail of the Utilization Management Department and someone will return your call. You are ultimately responsible for obtaining prior approval from the Utilization Management Department. Failure to obtain prior approval will result in a reduction to the Out-of-Network benefits level. However, information provided by the physician's office also satisfies this requirement.
Limitation	We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option,** we have no calendar year deductible for In Network services.
- **Under Standard Option,** the calendar year deductible for Participating Providers is $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under both High and Standard Options,** you must use Plan Providers; there are no Point of Service (Out-of-Network) benefits.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A plan physician, Nurse Practitioner, Physician's Assistant, or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a network pharmacy. If you choose to go to a non-network pharmacy, you must pay 100% of the costs of the medication to the pharmacy (except in an emergency). Some injectible drugs are obtained through mail order, For more information call Member Services at (605) 328-6800 for a copy of the Prescription Drug Brochure. To enroll and obtain prior-approval to join the Injectible Drugs Program call 1-800-278-0980.
- **How you can obtain them.** You must present your prescription ID card to your pharmacy, if you do not present your health plan ID card to your pharmacy, you must pay 100% of the costs of the medication to the pharmacy (except in an emergency).
- **We use an open formulary** that has three levels (or tiers):
  - **Level I** is the lowest copay and generally includes generic drugs but may include some brand formulary or preferred brands.
  - **Level II** represents the mid-range copays and generally includes brand formulary and preferred brands, but may include some generics and brands not included in Level I.
  - **Level III** is the highest copay and may include all other covered drugs not on Level II and III, such as non-formulary, or non-preferred drugs and some specialty drugs.

If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call (605) 328-6800 or 1-800-752-5863 or go to the Express Scripts website at www.sanfordhealthplan.com.

These are the dispensing limitations:

- **Prescriptions can be filled for up to a 30 day supply per copayment.** Those prescription drug classes identified as maintenance medications will be made available for up to a 90-day supply. However, three copayments will apply.
- **A generic equivalent will be dispensed if it is available,** unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. Additionally, if there is no generic equivalent, you will still be required to pay the brand name copayment.
- If there is a national emergency or you are called to active military duty, you may call our Member Services Department at (605) 328-6800 to request an exception for dispensing limitations.

Why use generic drugs? To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.

When you do have to file a claim. If you fail to use your health plan ID card to purchase prescription drugs, you must submit the claims directly to us at: Sioux Valley Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. Claim forms are available at your request. You may, however, submit your itemized prescription receipt with date, supply, drug name, and all necessary member information in lieu of a claim form.

Benefit Description	You pay	
Covered medications and supplies	**High Option**	**Standard Option**
We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy: • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as *Not covered* • Self administered injectible drugs • Drugs for sexual dysfunction limited per policy guidelines. Contact the Plan for details. Viagra limited to 4 pills per month. (see Section 3, *Services requiring our Prior approval*) • Contraceptive drugs and devices • Human Growth Hormones (see Section 3, *Services requiring our Prior approval*)	$15 per formulary generic drug $30 per formulary brand name drug $50 per non-formulary brand name drug. Note: If you request that you receive the brand name drug when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic in addition to your copay.	$15 per formulary generic drug $30 per formulary brand name drug $50 per non-formulary brand name drug. Note: If you request that you receive the brand name drug when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic in addition to your copay.
Diabetic Drugs/Supplies • Insulin vials • Blood glucose monitors • Insulin infusion devices, pumps and all supplies for pump • Prescribed oral agents for controlling blood sugars • Lancets and lancet devices • Blood/urine testing strips (maximum of 200 strips per month supply) • Glucose agents • Glucagon kits • Syringes for the administration of covered medications	$15 copay per one month supply for each individual item	$15 copay per one month supply for each individual item (No deductible)
Insulin Pens, Cartridges & Innolets	$30 per one month supply	$30 per one month supply
Prescription smoking cessation drugs (Note: over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence require a written prescription).	Nothing	Nothing (No deductible)

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	**High Option**	**Standard Option**
Not covered: • *Drugs and supplies for cosmetic purposes including baldness and appetitite suppressants* • *Drugs to enhance athletic performance* • *Fertility drugs* • *Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies* • *Vitamins, nutrients and food supplements even if a physician prescribes or administers them* • *Medication available over the counter (OTC) (except prescribed smoking cessation drugs as described above)* • *Orthomolecular therapy including nutrients, vitamins* • *B-12 injections, except for pernicious anemia* • *Compound medications with no legend medication* • *Acne medication for members over age thirty-five* • *Nonprescription medicines except Tobacco Cessation Drugs* Note: Over-the-counter and prescription drugs approved by the FDA to treat tobacco dependence are covered under the Tobacco cessation benefit. (See page 29.)	*All charges*	*All charges*

Section 5(g). Special features

Feature	Description
Flexible benefits option	Under the flexible benefits option, we determine the most effective way to provide services. • We may identify medically appropriate alternatives to regular contract benefits as a less costly alternative. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms in addition to other terms as necessary. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we do not guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular contract benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process. However, if at the time we make a decision regarding alternative benefits, we also decide that regular contract benefits are not payable, then you may dispute our regular contract benefits decision under the OPM disputed claims process (see Section 8).
24 hour nurse line	For any of your health concerns, 24 hours a day, 7 days a week, you may call Health Information at (605) 333-4444 and talk with a registered nurse who will discuss treatment options and answer your health questions.
Services for deaf and hearing impaired	Hearing impaired members wishing to speak to Member Services may contact: • Communication Services for the Deaf at (605) 362-3507 and ask for the head scheduler to arrange for an interpreter; • Community Resources for the Deaf at (605) 367-5759; or • For our hearing impaired members in surrounding states, a Relay System is available by calling 1-800-877-1113.
Interpreter Services	The Member Services and Utilization Management Departments have access to interpreter services in order to coordinate services by phone. A member who speaks a foreign language may request a Plan representative contact Lutheran Social Services at 1-866-242-2447 or A-2-Z at 1-800-757-3775 in the language of their choice. Once an interpreter is contacted, a three-way conversation will take place between the member, Plan representative and the interpreter.
Pregnancy programs and High risk pregnancies	Individuals may contact the Healthy Pregnancy Program at 1-800-752-5863 to enroll.
Centers of excellence	We utilize the contracted Centers of Excellence Network for transplant services. Please contact us at (605) 328-6807 for any information needed.
Services for visually impaired	The Plan will make available upon request large print Handbooks for visually impaired members. Please contact our Member Services Department if you are in need of a large print copy or cassette/CD of the Handbook or other member materials.

Feature	Description
Account Management Tools	Sanford's ***myHealthPlan*** is your online access to a variety of Member Services including: • Finding a Participating Practitioner and/or Provider online; • Ordering replacement ID Cards; • Viewing authorization and referral requests; • Viewing your personalized benefit plans; • Updating personal information such as your name and address; and • Viewing your claims status through an online Explanation of Benefits (EOB). Sanford's ***myHealthPlan*** is available to you and every dependent on your plan. To access ***myHealthPlan***, each member must sign up and register using a username and password that is chosen by the member. Health information is kept confidential and secure through this registration process. To register today, simply go to www.sanfordhealthplan.com and click on "Access ***myHealthPlan."***

Section 5(h). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- **Under High Option,** we have no calendar year deductible for In Network services.
- **Under Standard Option,** the calendar year deductible for Participating Providers is $500 per person ($1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- **Under both High and Standard Options,** you must use Plan Providers in order to receive in-network benefit coverage.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services,* for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU OR YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR SOME DENTAL PROCEDURES.** Please refer to the prior approval information shown in Section 3 to be sure which services require prior approval.

Benefit Decsription	You Pay	
Accidental injury benefit	**High Option**	**Standard Option**
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth (this does not include replacements including crowns, bridges or implants) as long as the patient was covered under the Plan during the time of the injury or illness causing the damage and receives care within six (6) months of the occurrence. The need for these services must result from an accidental injury or cancer.	$30 per specialist visit $50 per outpatient surgery $100 per day copay up to $500 per inpatient admission	20% of charges for specialist visit or outpatient surgery $100 per day copay up to $500 per inpatient admission
Dental benefits	**High Option**	**Standard Option**
• Dental services required for cancer that damages sound natural teeth • Associated radiology services	$30 per specialist visit $50 per outpatient surgery $100 per day copay up to $500 per inpatient admission	$30 per specialist visit $50 per outpatient surgery $100 per day copay up to $500 per inpatient admission
We have no other dental benefits.	*All charges*	*All charges*

Section 5(i). Point of Service benefits

- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option,** the calendar year deductible is $500 per person and $1,000 per family.
- **Under Standard Option,** the calendar year deductible for non-Participating Providers is $1,000 per person and $3,000 per family. The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost-sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Facts about this Plan's POS option
You may choose to obtain benefits covered by our POS: options from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under "What is not covered." Benefits not covered under POS must be received by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without authorization from us, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered:

- Medical Office Visits
- Preventive Health Services including Well Baby and Well Child Care (up to 6 years old), routine periodic preventive health exams, immunizations, allergy testing and treatment, and allergy serum
- Emergency Services (No deductible)
- X-Ray and Laboratory Services
- Acute Inpatient Hospital Services
- Maternity, Pregnancy and Newborn Care
- Inpatient Physician Services and Consultations
- Outpatient Hospital Services
- Outpatient Surgery
- Home Health Care
- Skilled Nursing Facility Service
- Mental Health Services
- Inpatient Chemical Dependency Services
- Inpatient Alcohol Treatment
- Durable Medical Equipment and Prosthetic Devices (Prior approval required for rentals or purchases over $200)
- Orthopedic Appliances
- Outpatient Rehabilitative Therapy
- Oral Surgery and Other Dental Services
- Ambulance and other transportation services

What you pay for benefits:
Under **High and Standard Options**, you pay 40% of the allowed benefit after paying the deductible and any charges greater than the allowed benefit. All participating providers are paid at the In-Network Benefit level and only the Out-of-Network doctor and/or facility charges are paid at the Out-of-Network POS level. Services obtained within or outside of the service area by non-Plan Participating Providers are eligible for coverage under POS.

How to obtain benefits:
To access POS benefits you may see the physician or obtain services at the facility of your choice. Benefits will be paid at 60% after the Out-of-Network deductible is met; you pay 40%, except for ambulance and other transportation services and outpatient substance abuse services which have a different coinsurance. We will need a claim from you, including a CPT code, date of service, diagnosis code, name of doctor or hospital, member's birthdate and identification number. Submit your claims to: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110

Deductible	The deductible is the amount that you must pay at the time services are received before we will pay for such services. The calendar year deductible applies to almost all benefits in this section. We added "(No deductible)" to show when the calendar year deductible does not apply. Under **High Option**, the calendar year deductible is $500 per person and $1,000 per family for Non-Participating Providers. Under **Standard Option**, the calendar year deductible for Non-Participating Providers is $1,000 per person and $3,000 per family.
Coinsurance	Coinsurance is the percentage of charges to be paid by you for services at the time such services are rendered. Our coinsurance for Point of Service benefits is 60%; you pay 40%, except for ambulance and other transportation services and outpatient substance abuse services which have a different coinsurance. The fee schedule is set at the 90th percentile of the standard Usual and Customary Rate (UCR) allowance for our region. You will be liable for your coinsurance percentage plus any charges in excess of the UCR allowance.
Maximum benefit	There is no lifetime maximum benefit under the POS plan.
Catastrophic Protection Out-of-pocket maximum	The catastrophic limit on your out-of-pocket Point of Service expenses per calendar year is $10,000 for the individual and $10,000 for the family (this does not apply to transplant services). Your out-of-pocket expenses under POS qualify for our catastrophic protection out-of-pocket maximum.
Outpatient substance abuse benefits	You pay 40% of our allowed benefit after the deductible for all covered chemical dependency and alcohol treatment services.
Ambulance and other transportation services	Under High Option, you pay $50 copay for emergency services. For non-emergency transportation you pay 20% of our allowed benefit unless you receive prior approval from the Plan. Under Standard Option, you pay 20% of our allowed benefit and any charges above the allowed benefit, after the deductible, for all covered services. For non-emergency transportation you pay 40% of our allowed benefit unless you receive prior approval from the Plan.
Emergency services	Medical emergency services as defined in Section 5(d) is always payable as an in-Plan benefit; there is a $100 per day copay up to $500 per inpatient admission, but the copay is waived if admitted.
What is not covered	• Tobacco Treatment; • Services list as not covered in Section 5; • Chiropractic Services; • Transplants at Non-Participating Center of Excellence Facilities; • Custodial care; and • All other services not listed in the "What is covered" Section above.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition. For information on obtaining prior approval for specific services, such as transplants, see Section 3 *When you need prior Plan approval for certain services.*

We do not cover the following:

- Care by non-plan providers except for authorized referrals or emergencies (see *Emergency services/accidents*).
- Services, drugs, or supplies you receive while you are not enrolled in this Plan.
- Services, drugs, or supplies not medically necessary.
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice.
- Experimental or investigational procedures, treatments, drugs or devices (see specifics regarding transplants).
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest.
- Services, drugs, or supplies related to sex transformations.
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program.
- Services, drugs, or supplies you receive without charge while in active military service.
- Health Care Services performed by any Provider who is a Member of the enrollee'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.
- Extra care and research costs associated with clinical trials.

Section 7. Filing a claim for covered services

This Section primarily deals with post-service claims (claims for services, drugs or supplies you have already received). See Section 3 for information on pre-service claims procedures (services, drugs or supplies requiring prior Plan approval), including urgent care claims procedures. When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider.

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

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call Member Services at (605) 328-6800 or toll free at 1-800-752-5863 or at our Web site at www.sanfordhealthplan.com.

When you must file a claim – such as for services you received outside the Plan's service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member's name, date of birth, address, phone number and ID number
- Name and address of the physician or facility that provided the service or supply
- Dates you received the services or supplies
- Diagnosis
- Type of each service or supply
- The charge for each service or supply
- A copy of the explanation of benefits, payments, or denial from any primary payor – such as the Medicare Summary Notice (MSN)
- Receipts, if you paid for your services

Note: Canceled checks, cash register receipts, or balance due statements are not acceptable substitutes for itemized bills.

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

Prescription drugs, other supplies or services

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

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

Post-service claims procedures

We will notify you of our decision within 30 days after we receive the claim. If matters beyond our control require an extension of time, we may take up to an additional 15 days for review as long as we notify you before the expiration of the original 30-day period. Our notice will include the circumstances underlying the request for the extension and the date when a decision is expected.

If we need an extension because we have not received necessary information from you, our notice will describe the specific information required and we will allow you up to 60 days from the receipt of the notice to provide the information.

Authorized Representative

You may designate an authorized representative to act on your behalf for filing a claim or to appeal claims decisions to us. For urgent care claims, we will permit a health care professional with knowledge of your medical condition to act as your authorized representative without your express consent. For the purposes of this section, we are also referring to your authorized representative when we refer to you.

Section 8. The disputed claims process

You may be able to appeal directly to the Office of Personnel Management (OPM) if we do not follow required claims processes. For more information about situations in which you are entitled to immediately appeal to OPM, including additional requirements not listed in Sections 3, 7 and 8 of this brochure, please visit www.sanfordhealthplan.com and log into your ***myHealthPlan*** account.

Please follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your post-service claim (a claim where services, drugs or supplies have already been provided). In Section 3 *If you disagree with our pre-service claim decision,* we describe the process you need to follow if you have a claim for services, referrals, drugs or supplies that must have prior Plan approval, such as inpatient hospital admissions.

To help you prepare your appeal, you may arrange with us to review and copy, free of charge, all relevant materials and Plan documents under our control relating to your claim, including those that involve any expert review(s) of your claim.

Step	Description
1	Ask us in writing to reconsider our initial decision. You must: a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms. e) Include your email address (optional), if you would like to receive our decision via email. Please note that by giving us your email, we may be able to provide our decision more quickly. We will provide you, free of charge and in a timely manner, with any new or additional evidence considered, relied upon, or generated by us or at our direction in connection with your claim and any new rationale for our claim decision. We will provide you with this information sufficiently in advance of the date that we are required to provide you with our reconsideration decision to allow you a reasonable opportunity to respond to us before that date. However, our failure to provide you with new evidence or rationale in sufficient time to allow you to timely respond shall not invalidate our decision on reconsideration. You may respond to that new evidence or rationale at the OPM review stage described in step 4.
2	In the case of a post-service claim, we have 30 days from the date we receive your request to: a) Pay the claim or b) Write to you and maintain our denial or. c) Ask you or your provider for more information You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days. If we do not receive the information within 60 days we will decide within 30 days of the date the information was due. We will base our decision on the information we already have. We will write to you with our decision.
3	If you do not agree with our decision, you may ask OPM to review it. You must write to OPM within: • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us -- if we did not answer that request in some way within 30 days; or 120 days after we asked for additional information.

	Write to OPM at: United States Office of Personnel Management, Healthcare and Insurance, Federal Employee Insurance Operations, Health Insurance 3, 1900 E Street, NW, Washington, DC 20415-3630. Send OPM the following information: • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. • Your email address, if you would like to receive OPM's decision via email. Please note that by providing your email address, you may receive OPM's decision more quickly. Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim. Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request. However, for urgent care claims, a health care professional with knowledge of your medical condition may act as your authorized representative without your express consent. Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.
4	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended. OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute. Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (800) 805-7938. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance 3 at (202) 606-3818 between 8 a.m. and 5 p.m. eastern time.
5	OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals. If you do not agree with OPM's decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.

	OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record. You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and you did not indicate that your claim was a claim for urgent care, then call us at (605) 328-6807. We will hasten our review (if we have not yet responded to your claim); or we will inform OPM so they can quickly review your claim on appeal. You may call OPM's Health Insurance HI 3 at

(202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called "double coverage."

When you have double coverage, one plan normally pays its benefits in full as the primary payor and the other plan pays a reduced benefit as the secondary payor. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners' guidelines.

When we are the primary payor, we will pay the benefits described in this brochure.

When Sanford Health Plan is the secondary payor and Medicare is primary, we pay the lesser of our allowance or the difference between our allowance and what is paid by Medicare. The following is an example of how Sanford Health Plan will pay your claims when Medicare is primary and your Sanford Health Plan is secondary. Below is an example of the Standard option for inpatient hospital services:

Inpatient Hospital billed amount:	$10,000
Medicare allowance:	$9,000
Medicare payment (80% of allowance):	$7,200
Balance after Medicare payment:	$1,800
Member Responsibility (Standard option): Note: This equals a 5-day hospital stay or $500 deductible amount	$500
Plan Pays ($1,800 - $500):	$1,300

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older
- Some people with disabilities under 65 years of age
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant)

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-4820) for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.

- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare's Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It's easy. Just call the Social Security Administration toll-free number 1-800-772-1213 (TTY 1-800-325-0778) to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage. If you do not sign up for Medicare Part B when you are first eligible, you may be charged a Medicare Part B late enrollment penalty of a 10 % increase in premium for every 12 months you are not enrolled. If you didn't take Part B at age 65 because you were covered under FEHB as an active employee (or you were covered under your spouse's group health insurance plan and he/she was an active employee), you may sign up for Part B (generally without an increased premium) within 8 months from the time you or your spouse stop working or are no longer covered by the group plan. You also can sign up at any time while you are covered by the group plan.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan. **(Please refer to page 61 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)**

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

All physicians and other providers are required by law to file claims directly to Medicare for members with Medicare Part B, when Medicare is primary. This is true whether or not they accept Medicare.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payor, we process the claim first.

When Original Medicare is the primary payor, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at (605) 328-6800 or 1-800-752-5863 or see our website at www.sanfordhealthplan.com.

We waive some costs if the Original Medicare Plan is your primary payor – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

We do not waive any costs if the Original Medicare Plan is your primary payor.

You can find out more information about how our plan coordinates benefits with Medicare by calling Member Services at (605) 328-6800 (toll free at 1-800-752-5863).

Tell us about your Medicare coverage

You must tell us if you or a covered family member has Medicare coverage, and let us obtain information about services denied or paid under Medicare if we ask. You must also tell us about other coverage you or your covered family members may have, as this coverage may affect the primary/secondary status of this Plan and Medicare.

Medicare Advantage (Part C)

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227), (TTY 1-877-486-2048) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

Medicare prescription drug coverage (Part D)

When we are the primary payor, we process the claim first. If you enroll in Medicare Part D and we are the secondary payor, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Medicare always makes the final determination as to whether they are the primary payor. The following chart illustrates whether Medicare or this Plan should be the primary payor for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payor Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	**The primary payor for the individual with Medicare is...**	
	Medicare	**This Plan**
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓*	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD **(30-month coordination period)**		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payor before eligibility due to ESRD **(for 30 month coordination period)**		✓
• Medicare was the primary payor before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD **(for the 30 month coordination period)**		✓
• Medicare based on ESRD **(after the 30 month coordination period)**	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

TRICARE and CHAMPVA

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You (or a covered family member) need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

When other Government agencies are responsible for your care

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

When others are responsible for injuries

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Coverage Clinical Trials

If you are a participant in a clinical trial, this Health Plan will provide related care as follows, if it is not provided by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care. This Plan does not cover these costs.

- Research costs – costs related to conducting the 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 clinical trials, this Plan does not cover these costs.

Section 10. Definitions of terms we use in this brochure

Calendar year

January 1 through Dec. 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on Dec. 31 of the same year.

Clinical Trials Cost Categories

Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition whether the patient is in a clinical trial or is receiving standard therapy.

Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of the trial, but not as part of the patient's routine care.

Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes.

Coinsurance

Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See Section 4.

Copayment

A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.

Cost-sharing

Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Covered services

Care we provide benefits for, as described in this brochure.

Custodial care

Care in which room, board, and other personal assistance services are provided, generally on a long-term basis and which does not include a medical component.

Deductible

A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.

Experimental or investigational service

Any healthcare services where the Healthcare service in question is either: 1) 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 2) requires approval by any governmental authority and such approval has not been granted prior to the service being rendered.

Health care professional

A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Medical necessity

Health care services that are appropriate, in terms or type, frequency, level, setting, and duration, to your diagnosis or condition, and diagnostic testing and preventative services. Medically necessary care must:

- Be consistent with generally accepted standards of medical practice as recognized by the Plan, as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and
- Help restore or maintain your health; or
- Prevent deterioration of your condition; or
- Prevent the likely onset of a health problem or detect an incipient problem; or
- Not considered experimental or investigative.

For non-solid organ tissue transplants, the medical necessity requirement is considered satisfied whenever the patient meets the staging description and can safely tolerate the procedure.

Plan allowance

Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:

- For in-network coverage the allowance is based on a percent of discounted charges that the Plan has negotiated with Participating Providers; in-network providers accept the Plan allowance as payment in full.
- For Out-of-Network providers the allowance is based on a percent of eligible reasonable and customary charges.

Post-service claims

Any claims that are not pre-service claims. In other words, post-service claims are those claims where treatment has been performed and the claims have been sent to us in order to apply for benefits.

Pre-service claims

Those claims (1) that require precertification, prior approval, or a referral and (2) where failure to obtain precertification, prior approval, or a referral results in a reduction of benefits.

Urgent care claims

A claim for medical care or treatment is an urgent care claim if waiting for the regular time limit for non-urgent care claims could have one of the following impacts:

- Waiting could seriously jeopardize your life or health;
- Waiting could seriously jeopardize your ability to regain maximum function; or
- In the opinion of a physician with knowledge of your medical condition, waiting would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Urgent care claims usually involve Pre-service claims and not Post-service claims. We will judge whether a claim is an urgent care claim by applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

If you believe your claim qualifies as an urgent care claim, please contact our Member Services Department at (605) 328-6800 (toll free at 1-800-752-5863). You may also prove that your claim is an urgent care claim by providing evidence that a physician with knowledge of your medical condition has determined that your claim involves urgent care.

Us/We

Us and We refer to Sanford Health Plan.

You

You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits,* brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment
- How you can cover your family members
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire
- What happens when your enrollment ends
- When the next open season for enrollment begins

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office. For information on your premium deductions, you must also contact your employing or retirement office.

Types of coverage available for you and your family

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children, including any foster children your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately of changes in family member status including your marriage, divorce, annulment, or when your child reaches age 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Family member coverage**

Family members covered under your Self and Family enrollment are your spouse (including a valid common law marriage) and children as described in the chart below.

Children	Coverage
Natural, adopted children, and step children	Natural, adopted children and step children are covered until their 26th birthday.
Foster Children	Foster children are eligible for coverage until their 26th birthday if you provide documentation of your regular and substantial support of the child and sign a certificaiton stating that your foster child meets all the requirements. Contact your human resources office or retirement system for additional information.
Children Incapable of Self-Support	Children who are incapable of self-support because of a mental or physical disability that began before age 26 are eligible to continue coverage. Contact your human resources office or retirement system for additional information.
Married Children	Married children (but NOT their spouse or their own children) are covered until their 26th birthday.
Children with or eligible for employer-provided health insurance	Children who are eligible for or have their own employer-provided health insurance are covered until their 26th birthday.

You can find additional information at www.opm.gov/insure.

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your dependent children under age 26, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 26 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including divorce, annulment, or when your child under age 26 turns 26.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;

- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

- **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2012 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2011 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

If your enrollment continues after you are no longer eligible for coverage (i.e. you have separated from Federal service) and premiums are not paid, you will be responsible for all benefits paid during the period in which premiums were not paid. You may be billed for services received directly from your provider. You may be prosecuted for fraud for knowingly using health insurance benefits for which you have not paid premiums. It is your responsibility to know when you or a family member are no longer eligible to use your health insurance coverage.

- **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

- **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment; or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC).

If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 26, etc. You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees,* from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program.* See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Other Federal Programs

Important information about three Federal programs that complement the FEHB Program

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of $250 and a maximum annual election of $5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, insulin, products, and physician prescribed over-the-counter drugs and medications, vision and dental expenses, and much more) for you and your tax dependents, including adult children (through the end of the calendar year in which they turn age 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA**) – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your tax dependents including adult children (through the end of the calendar year in which they turn age 26) which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Dependent Care FSA (DCFSA)** – Reimburses you for eligible **non-medical** day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.
- If you are a new or newly eligible employee you have 60 days from your hire date to enroll in an HCFSA or LEX HCFSA and/or DCFSA, but you must enroll before October 1. If you are hired or become eligible on or after October 1 you must wait and enroll during the Federal Benefits Open Season held each fall.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is separate and different from the FEHB Program and was established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations for enrollment.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

All dental plans provide a comprehensive range of services, including:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.
- Class D (Orthodontic) services with up to a 24-month waiting period for dependent children up to age 19.

Vision Insurance

All vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/vision and www.opm.gov/insure/dental. These sites also provide links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP*

It's important protection

The Federal Long Term Care Insurance Program (FLTCIP) can help pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment such as Alzheimer's disease. For example, long term care can be received in your home from a home health aide, in a nursing home, in an assisted lving facility, or in adult day care. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Federal and U.S. Postal Service employees and annuitants, active and retired members of the uniformed services, and qualified relatives, are eligible to apply. Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. For more information, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

Pre-existing Condition Insurance Program (PCIP)

Do you know someone who needs health insurance but can't get it? The Pre-Existing Condition Insurance Plan (PCIP) may help.

An individual is eligible to buy coverage in PCIP if:

- He or she has a pre-existing medical condition or has been denied coverage because of the health condition;
- He or she has been without health coverage for at least the last six months. (If the individual currently has insurance coverage that does not cover the pre-existing condition or is enrolled in a state high risk pool then that person is not eligible for PCIP.);
- He or she is a citizen or national of the United States or resides in the U.S. legally.

The Federal government administers PCIP in the following states: Alabama, Arizona, District of Columbia, Delaware, Florida, Georgia, Hawaii, Idaho, Indiana, Kentucky, Louisiana, Massachusetts, Minnesota, Mississippi, North Dakota, Nebraska, Nevada, South Carolina, Tennessee, Texas, Vermont, Virginia, West Virginia, and Wyoming. To find out about eligibility, visit www.pcip.gov and/or www.healthcare.gov or call 1-866-717-5826 (TTY): 1-866-561-1604.

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Summary of benefits for the High Option of Sanford Health Plan - 2012

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions , limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- You are only subject to the calendar year deductible when you use our Point of Services (POS) benefits.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $20 primary care; $30 specialist	20
Services provided by a hospital:		
• Inpatient	$100 per day copay up to $500 per admission	38
• Outpatient	$50 per visit	39
• Outpatient Hospital Services	Nothing	39
Emergency benefits:		
• In-area or out-of-area	$100 per visit, waive if admitted	41
Mental health and substance abuse treatment:	Regular cost-sharing	44
Prescription drugs 30 day supply:		
• Generic drugs • Formulary brand name drugs • Non-formulary brand name drugs	• $15 copay • $30 copay • $50 copay Note: If there is no generic equivalent available, you will still have to pay the brand name copay	47
Dental care:	No benefit	50
Vision care: Eye exams for children through age 17	Nothing	21
Special features: Flexible benefits option, 24 hour nurse line, Services for deaf and hearing impaired, Services for visually impaired, Interpreter services, Pregnancy programs, and Centers of Excellence.	Nothing	51
Point of Service benefits: Yes	Generally 40% of the allowed benefit after paying the deductible and any charges greater than the allowed benefit.	53
Protection against catastrophic costs (out-of-pocket maximum)**:**	Nothing after $4,000 Self Only or $4,000 Family enrollment per year. Any costs above reasonable and customary charges do not count towards this protection.	15

Summary of benefits for the Standard Option of Sanford Health Plan - 2012

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the $500/Self Only and $1,000/Family calendar year deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: $25 primary care; $25 specialist	20
Services provided by a hospital:		
• Inpatient	$100 copay per day up to $500 per admission*	38
• Outpatient	20% coinsurance*	39
• Outpatient Hospital Services	20% coinsurance*	39
Emergency benefits:		
• In-area and out-of-area	$100 per visit, waive if admitted	41
Mental health and substance abuse treatment:	Regular cost-sharing*	44
Prescription drugs 30 day supply:		
• Generic drugs • Formulary brand name drugs • Non-formulary brand name drugs	• $15 copay • $30 copay • $50 copay Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	47
Dental care:	No benefit*	50
Vision care: Eye exams for children through age 17	Nothing (No deductible)	21
Special features: Flexible benefits option, 24 hour nurse line, Services for the deaf and hearing impaired, Services for the visually impaired, Interpreter services, Healthy Pregnancy program, Centers of Excellence	Nothing	51
Point of Service benefits: Yes	Generally 40% of the allowed benefit after paying the deductible and any charges greater than the allowed benefit*	53
Protection against catastrophic costs (out-of-pocket maximum)**:**		15

	Nothing after $3,000 Self Only or $4,000 Family enrollment per year. Any costs above reasonable and customary charges do not count towards this protection.	

2012 Rate Information for Sanford Health Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the *Guide to Federal Benefits* for that category or contact the agency that maintains your health benefits enrollment.

Postal Category 1rates apply to career employees covered by the National Postal Mail Handlers Union (NPMHU), National Association of Letter Carriers (NALC) and Postal Police bargaining units.

Postal Category 2rates apply to other non-APWU, non-PCES, non-law enforcement Postal Service career employees, including management employees, and employees covered by the National Rural Letter Carriers' Association bargaining unit.

Special Guides to Benefits are published for American Postal Workers Union (APWU) employees (see RI 70-2A) including Material Distribution Center, Operating Services and Information Technology/Accounting Services employees and Nurses; Postal Service Inspectors and Office of Inspector General (OIG) law enforcement employees (see RI 70-2IN), Postal Career Executive Service (PCES) employees (see RI 70-2EX), and noncareer employees (see RI 70-8PS).

Career APWU employees hired before May 23, 2011, will have the same rates as the Category 2 rates shown below. In the Guide to Benefits for APWU Employees (RI 70-2A) this will be referred to as the "Current" rate; otherwise, "New" rates apply.

For further assistance, Postal Service employees should call:

- Human Resources Shared Service Center
- 1-877-477-3273, option 5
- TTY: 1-866-260-7507

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable *Guide to Federal Benefits.*

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	Category 1 Your Share	Category 2 Your Share
Central, Eastern South Dakota and the Rapid City Area and Northwestern Iowa							
High Option Self Only	AU1	$185.75	$117.33	$402.46	$254.21	$96.70	$94.12
High Option Self and Family	AU2	$414.35	$282.97	$897.76	$613.10	$236.93	$231.17
Standard Option Self Only	AU4	$185.75	$105.72	$402.46	$229.06	$85.09	$82.51
Standard Option Self and Family	AU5	$414.35	$256.05	$897.76	$554.77	$210.01	$204.25