

State of North Dakota
Department of Human Services



Mental Health Parity
Compliance Documentation
ND Medicaid Expansion Program
Calendar Year 2020 and 2021



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Common Terms and Acronyms

| Acronym | Term |
|---------|---|
| ABA | Applied Behavior Analysis |
| ABP | Alternative Benefit Plan |
| ACA | Affordable Care Act |
| ADHD | Attention Deficit Hyperactivity Disorder |
| AL/ADL | Aggregate Lifetime and Annual Dollar Limits |
| CHIP | Children's Health Insurance Program |
| CMS | Centers for Medicare & Medicaid Services |
| DME | Durable Medical Equipment |
| DHS | Department of Human Services |
| DRG | Drug Related Group |
| DSM | Diagnostic and Statistical Manual of Mental Disorders |
| DUR | Drug Utilization Review |
| ED | Emergency Department |
| EHB | Essential Health Benefit |
| EPSDT | Early and Periodic Screening, Diagnostic, and Treatment |
| ER | Emergency Room |
| FDA | Food and Drug Administration |
| FFS | Fee-For-Service |
| FQHCs | Federally Qualified Health Centers |
| FR | Financial Requirements |
| GLOS | Goal Length of Stay |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| ICD | International Classification of Diseases |
| IHCP | Indian Health Care Provider |
| IMD | Institutions of Mental Diseases |
| IP | Inpatient |
| MCG | Milliman Care Guidelines |
| MCO | Managed Care Organization |
| MH | Mental Health |
| MHPAEA | Mental Health Parity and Addiction Equity Act of 2008 |
| MRI | Magnetic Resonance Imaging |
| M/S | Medical/Surgical |
| NQTL | Non-Qualitative Treatment Limit |
| OP | Outpatient |
| OTP | Opioid Treatment Programs |
| P&T | Pharmacy and Therapeutics |

| | |
|-------|---|
| PA | Prior Authorization |
| PCP | Primary Care Provider |
| PDL | Preferred Drug List |
| PQC | Physician Quality Committee |
| PRP | Platelet Rich Plasma |
| QM/UM | Quality Management/Utilization Management Committee |
| QTL | Quantitative Treatment Limit |
| R&B | Room and Board |
| RX | Prescription Drug |
| SA | Substance Abuse |
| SPA | State Plan Amendment |
| SHP | Sanford Health Plan |
| SUD | Substance Use Disorder |
| TMJ | Temporomandibular Joint (TMJ) syndrome |
| UR | Utilization Review |
| VA | Veteran Affairs |

1.0 Introduction

In 2008, Congress passed the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). The MHPAEA requires insurers and plans to guarantee that all financial requirements (i.e., deductibles, co-pays), as well as caps and limitations on benefits, be no more restrictive for mental health (MH) services than for medical and surgical counterparts under the same plan.

The Affordable Care Act (ACA) built upon the MHPAEA by including MH services as an essential health benefit (EHB) and mandating that parity rules apply to individual and small-group markets. On March 30, 2016, Centers for Medicare & Medicaid Services (CMS) finalized the MH and substance use disorder (SUD) parity rule for Medicaid and the Insurance Program (CHIP) effective May 31, 2016. This final rule applied parity rules to Medicaid MCOs, Medicaid benchmark and benchmark-equivalent plans (referred to in this rule as Medicaid ABPs), as well as CHIP. In January 2017, the CMS issued rules, guidance, and a toolkit to assist the states in achieving compliance with the law.

Sanford Health Plan (SHP) is the Medicaid managed care program for North Dakota expansion population. This document analyzes and demonstrates North Dakota Medicaid Expansion's compliance with the MHPAEA.

2.0 Methodology

2.1 Benefit Package Identification Process

North Dakota Medicaid expansion population utilizes the Alternative Benefit Plan (ABP) except for those who are deemed medically frail, at which time the Traditional benefit package is accessible. The ABP State Plan Amendment (SPA) was last revised with CMS approval granted for an effective date of October 2020.

2.2 Process to Determine Responsibility for Parity Analysis

For the North Dakota Medicaid expansion population most benefits within the ABP are administered and managed through managed care organization. However, pharmacy services were carved out of managed care as of January 1, 2020 and are provided by FFS basis to North Dakota Medicaid expansion members.

Because of the mixed delivery system, the State is responsible for conducting the parity analysis.

3.0 Definitions

3.1 Benefit Groupings

3.1.1 Medical/Surgical (M/S) Benefits

Medical/surgical benefits means benefits with respect to items or services for medical conditions or surgical procedures, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law, but not including mental health or substance use disorder benefits. North Dakota had selected the current edition of the International Statistical Classification of Diseases and Related Health Problems (ICD), as the generally recognized diagnostic standard for identifying medical/surgical services and distinguishing M/S for procedure codes that can be used in both an M/S and MH/SUD context.

3.1.2 MH and SUD Benefits

Mental health and SUD benefits means benefits with respect to items or services for mental health conditions or SUD conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. North Dakota had selected the current edition of the International Statistical Classification of Diseases and Related Health Problems (ICD), as the generally recognized diagnostic standard for identifying MH and SUD services and distinguishing MH/SUD services for procedure codes that can be used in both an M/S and MH/SUD context.

3.2 Benefit Classifications

| Classification | Definition |
|-------------------|---|
| Inpatient | Services provided to a patient who is admitted into a hospital, acute care setting, psychiatric health facility or long-term facility under the recommendation of a physician. Inpatient services include all treatments, pharmaceutical, equipment, test, and procedures provided during an inpatient treatment episode. |
| Outpatient | Services provided to a patient who evaluated or treated in an outpatient clinic, outpatient hospital or community-based setting. Outpatient services include all treatments, equipment, tests, procedures, and clinician-administered pharmaceuticals provided during an outpatient treatment episode. |

| | |
|---------------------------|---|
| Emergency Care | Covered services or medications that are furnished by a qualified provider and are needed to evaluate or stabilize and emergency medical condition delivered in an emergency department (ED). |
| Prescription Drugs | Simple or compounded substance or mixture of substances prescribed for the cure, mitigation or prevention of a disease or health maintenance. Prescription drugs are dispensed by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder medication-assisted treatment. Prescription drug coverage is not provided by SHP. FFS ND Medicaid provides outpatient prescription drug coverage. |

4.0 Grouping and Classification of Benefits

4.1 Methodology

4.1.1 Benefit Grouping Process

North Dakota Medicaid requested the MCO provide analysis which focused on the following areas: authorization and referral process, pharmacy and drug formulary, provider network, credentialing and contracting, case management and care coordination, treatment restriction and/or exclusions, and financial requirements. Per their review they provided the breakdown of the classification of services provided in all the four classifications.

To group the pharmacy benefits, North Dakota used the First Databank HIC3 Class Codes, which group drugs into therapeutic classes. Subject matter experts manually reviewed covered therapeutic classes and assigned them to MH/SUD, M/S, or both.

4.1.2 Benefit Classification Process

To map non-pharmacy benefits to the inpatient, outpatient, prescription drug, and emergency care classifications as defined above, North Dakota reviewed the benefits in the Alternative Benefits Plan package against the agreed-upon definitions.

Pharmacy benefits were mapped to the prescription drug classification except drugs administered by a provider as part of an inpatient, outpatient, or emergency care episode of care.

4.2 Non-Pharmacy Benefit Grouping and Classification

The following table shows the North Dakota ABP plans non-pharmacy benefits grouped as MH, SUD, and M/S and classified as Inpatient, Outpatient, and Emergency Care. North Dakota ABP covers MH/SUD benefits in every classification in which there is an M/S benefit.

Table: Non-Pharmacy Benefit Grouping and Classification

| | Inpatient | Outpatient | Emergency Care |
|------------|---|--|---|
| M/S | <ul style="list-style-type: none"> - Surgery - Anesthesia - Semiprivate room - Medication administered during the admission - Lab - Radiology - Skilled nursing care - Detoxification - Semiprivate room - Methadone when ordered by a physician in a hospital for pain | <ul style="list-style-type: none"> - Preventive services - Primary care visit - Home-based nursing - Medication administered during the outpatient visit - Lab - Radiology - Personal care provided in the beneficiary's home - Detoxification - Home-based nursing | <ul style="list-style-type: none"> - Ambulance - Consultation delivered in an ED - Medications administered during an ED visit - Lab - Radiology provided in an ED |
| MH | <ul style="list-style-type: none"> - Psychiatric services - Psychotropic medication - Respite - Peer support | <ul style="list-style-type: none"> - Psychotherapy - Rehabilitation services - Respite - Peer support - Personal care provided in the beneficiary's home | <ul style="list-style-type: none"> - Crisis stabilization - Psychotropic medication administered in an ED - Emergency respite - Peer support |
| SUD | <ul style="list-style-type: none"> - Acute psychiatric services - Residential SUD services - Detoxification in combination with treatment for a SUD - Buprenorphine when prescribed by a certified physician in a hospital - Methadone when ordered by a physician in a hospital for SUD | <ul style="list-style-type: none"> - Community-based detoxification - Intensive Outpatient Program Services - Federally certified OTP services - Methadone when delivered through an OTP - Counseling and behavior therapy (required for buprenorphine) - Psychosocial rehab | <ul style="list-style-type: none"> - Crisis stabilization services - Naloxone |

4.3 Pharmacy Benefit Grouping and Classification

<http://hidesigns.com/ndmedicaid/pdl/2021.html>

5.0 Managed Care Organization Contract Compliance

North Dakota Medicaid expansion contract includes the following provisions requiring compliance with federal MH parity regulations, demonstrating compliance with 42 CFR Part 438.6(n).

5.1 Utilization Review and Control

Article 4 Benefits, Section 4.1 General Provisions, 4.1.1 Basic Standards notes the following:

- (A) MCO shall, pursuant to 42 CFR § 438.210(a)(4)(ii)(A), N.D.A.C. § 75-02-02-08, and the Alternative Benefit State Plan Amendment or Attachment C of this contract, provide to Enrollees, directly or through arrangements with Providers, all Medically Necessary Covered Services and services related to the prevention, diagnosis, and treatment of health impairments as promptly and continuously as is consistent with generally accepted standards of medical practice.
- (B) MCO shall, pursuant to 42 CFR § 438.206(a), ensure that all Covered Services are available and accessible to enrollees in a timely manner. MCO will also ensure provider networks for Covered Services under this contract meet the standards developed by STATE in accordance with 42 CFR § 438.68.
- (C) MCO shall ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which the services are furnished.
- (D) MCO may not arbitrarily deny or reduce the amount, duration, or scope of a required service solely because of diagnosis, type of illness, or condition of the beneficiary.
- (E) MCO may place appropriate limits on a service based on criteria applied under State Plan, such as Medical Necessity, or for the purpose of utilization control, provided the services furnished can reasonably be expected to achieve their purpose.
- (F) MCO shall, pursuant to 42 CFR § 438.210(a)(5)(i), provide for the utilization of Medically Necessary services provided under this contract in a manner that is no more restrictive than STATE'S Medicaid program and N.D.A.C. § 75-02-02-08.
- (G) MCO shall, pursuant to the 1915(b) Waiver, provide:
 - (1) Emergency Services - MCO will assure access to Emergency Services per Section 1932(b)(2) of the Social Security Act (42 U.S.C. § 1396u-2(b)(2)) and 42 CFR § 438.114(d)(1)(i).
 - (2) Family Planning Services - MCO shall assure access to family planning services per Section 1905(a)(4)(C) of the Social Security Act (42 U.S.C. § 1396d(a)(4)(C)) and 42 CFR § 431.51(b). In accordance with Sections 1905(a)(4)(C) and 1915(b) of the Social Security Act (42 U.S.C. § 1396n(b)) and 42 CFR § 431.51(b)(2), prior authorization of, or requiring the use of Network Providers for, family planning services is prohibited. MCO is required to reimburse Out-of-Network Providers for family planning services.
 - (3) FQHC Services - Reasonable access to FQHC services will be available under the 1915(b) Waiver program.
 - (4) MCO must ensure that the FQHCs and RHCs in the MCO Service Area are considered Network Providers. The Network Provider directory must specify that such FQHCs and RHCs are Network Providers and must include telephone and address information for each location.
 - (5) MCO shall, pursuant to Sections 1905(a)(4)(B) (services) (42 U.S.C. § 1396d(a)(4)(B)), 1902(a)(43) (42 U.S.C. § 1396a(a)(43)) (administrative requirements including informing, reporting, etc.), and 1905(r) (definition) of the Social Security Act (42 U.S.C. § 1396(r)),

meet Early, Periodic, Screening, Diagnosis, and Treatment (EPSDT) program requirements.

- (H) MCO shall, in accordance to the Alternative Benefit Plan State Benefit Plan, cover abortions under any of the following circumstances:
 - (1) If the pregnancy is the result of an act of rape or incest; or
 - (2) In the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, which would, as certified by a physician, place the woman in danger of death unless an abortion is performed
- (I) MCO shall, pursuant to 42 CFR § 438.210(a)(5)(ii)(B), N.D.A.C. § 75-02-02, and the Alternative Benefit Plan State Plan Amendment, cover Medically Necessary services related to the ability to achieve age-appropriate growth and development.
- (J) MCO shall, pursuant to 42 CFR § 438.210(a)(5)(ii)(C), N.D.A.C. § 75-02-02 and the Alternative Benefit Plan State Plan Amendment, cover Medically Necessary services related to the ability to attain, maintain, or regain functional capacity.
- (K) MCO shall, in accordance with 42 CFR § 431.53, ensure necessary transportation for nonemergency transportation services, including the reimbursement amount for providers, per best practice guidelines and standards it develops, as necessary to provide the covered service.

Article 4 Benefits, Section 4.2 Scope of Services, 4.2.1 Scope of Covered Services notes the following:

- (A) Except as otherwise provided for cases of Emergency Services, MCO is responsible to arrange for all Covered Services outlined in Attachment C and must include all necessary services to ensure the benefit package contains all EHBs, required Medicaid services, and is in compliance with the MHPAEA; provided, however, that Covered Services are limited to those provided within the United States.
- (B) MCO is responsible for payment of Emergency Services 24 hours a day, 7 days a week; and Post-Stabilization Services, whether these services were provided by a Network Provider or an Out-of-Network Provider, and whether the service was provided inside or outside of the MCO Service Area. Pursuant to Section 1932(b)(2) of the Social Security Act and 42 CFR § 438.114(c)(1)(ii)(A), MCO shall not deny payment of emergency and Post-Stabilization Services within the above scenarios. To be Covered Services, Health Care Services must be rendered within the United States.
- (C) MCO is responsible to pay for all services that are outlined in Attachment C.
 - (1) MCO may offer additional benefits beyond the minimum outlined in Attachment C.
 - (2) These additional benefits cannot be included within the Claims experience for future rate calculations.
 - (3) Any additional benefits that would be out of the scope of rate setting and, therefore, would also be out of the scope of any applicable settlements that result from any reconciliation, as described in Attachment F.
- (D) MCO shall, pursuant to 42 CFR § 493.1 and 42 CFR § 493.3, ensure all laboratory testing sites providing services under this contract have either a CLIA certificate or waiver of a certificate of registration along with a CLIA identification number.
- (E) MCO shall, pursuant to 42 CFR § 438.10(g)(2)(ii)(A) and 42 CFR § 438.102, allow STATE, if MCO does not cover counseling or referral services because of moral or religious objections, and chooses not to furnish information to Enrollees on how and where to obtain such services, to provide the information to Enrollees.

- (F) MCO shall not, pursuant to 42 CFR § 438.114(c)(1)(ii)(B), deny payment for treatment obtained when a representative of MCO instructs the Enrollee to seek Emergency Services.
- (G) MCO shall not, pursuant to 42 CFR § 438.114(d)(1)(i), limit what constitutes an Emergency Medical Condition on the basis of lists of diagnoses or symptoms.
- (H) MCO shall, pursuant to 42 CFR § 438.114(d)(1)(ii), allow the Emergency Services Provider ten (10) calendar days to notify the Primary Care Provider, MCO, or applicable State entity of the Enrollee's screening and treatment before refusing to cover the services based on a failure to notify.
- (I) MCO shall not, pursuant to 42 CFR § 438.114(d)(2), hold an Enrollee who has an Emergency Medical Condition liable for payment of subsequent screening and treatment needed to diagnose or stabilize the specific condition.
- (J) MCO shall, pursuant to 42 CFR § 438.114(d)(3), be responsible for coverage and payment of services until the attending emergency physician, or the Provider actually treating the Enrollee, determines that the Enrollee is sufficiently stabilized for transfer or discharge.
- (K) MCO shall, pursuant to 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(2)(i), cover Post-Stabilization Services obtained within or outside the MCO Network that are pre-approved by a MCO Provider or representative.
- (L) MCO shall, pursuant to 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(2)(ii) and (iii), cover Post-Stabilization Care Services obtained within or outside the MCO Network that are not preapproved by a MCO Provider or representative, but administered to maintain the Enrollee's stabilized condition within one hour of a request to MCO for pre-approval of further Post-Stabilization Care Services.
- (M) MCO shall, pursuant to 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(2)(iii)(A), cover post-stabilization care services administered to maintain, improve, or resolve the Enrollee's stabilized condition without preauthorization, and regardless of whether the Enrollee obtains the services within or outside of the MCO Network, when MCO did not respond to a request for pre-approval within one hour.
- (N) MCO shall, pursuant to 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(2)(iii)(B), cover post-stabilization care services administered to maintain, improve, or resolve the Enrollee's stabilized condition without preauthorization, and regardless of whether the Enrollee obtains the services within or outside of the MCO Network, when MCO could not be contacted for pre-approval.
- (O) MCO shall, pursuant to 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(2)(iii)(C), cover post-stabilization care services administered to maintain, improve, or resolve the Enrollee's stabilized condition without preauthorization, and regardless of whether the Enrollee obtains the services within or outside the MCO Network, when MCO representative and the treating physician could not reach agreement concerning the Enrollee's care and a MCO physician was not available for consultation.
- (P) MCO shall, pursuant to 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(2)(iv), limit charges to Enrollees for Post-Stabilization Care Services to an amount no greater than what MCO would charge the Enrollee if he or she obtained the services through MCO.
- (Q) Pursuant to 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(3)(i), MCO's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when a MCO physician with privileges at the treating hospital assumes responsibility for the Enrollee's care.
- (R) Pursuant to 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(3)(ii), MCO's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when a MCO physician assumes responsibility for the Enrollee's care through transfer.

- (S) Pursuant to 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(3)(iii), MCO's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when a MCO representative and the treating physician reach an agreement concerning the Enrollee's care.
- (T) Pursuant to 42 CFR § 438.114(e) and 42 CFR § 422.113(c)(3)(iv), MCO's financial responsibility for Post-Stabilization Care Services it has not pre-approved ends when the Enrollee is discharged.

5.2 Compliance with Applicable Laws, Rules, and Policies

Article 4 Benefits, Section 4.3 Mental Health and Substance Use Disorder Benefits notes the following:

MCO must provide Mental Health or Substance Use Disorder Benefits to Enrollees in every classification (inpatient, outpatient, emergency care, or prescription drugs) in which Medical/Surgical Benefits are provided as in accordance with applicable laws and regulations including 42 CFR § 438.910(b)(2) and 45 CFR § 146.136(c)(2)(ii).

Article 4 Benefits, Section 4.3 Mental Health and Substance Use Disorder Benefits, 4.3.1 Financial Requirements and Treatment Limitation MHPAEA Requirements notes the following:

- (A) MCO shall comply with parity requirements for aggregate lifetime and annual dollar limits in accordance with 45 CFR §146.136 and 42 CFR § 438.905(b), (c), or (e), as applicable.
- (B) MCO may not apply any financial requirement or treatment limitation to Mental Health or Substance Use Disorder Benefits in any classification that is more restrictive than the predominant financial requirement or treatment limitation of that type applied to substantially all Medical/Surgical Benefits in the same classification furnished to Enrollees (whether or not the benefits are furnished by the same MCO) as in accordance to 42 CFR § 438.910(b)(1) and the applicable provisions in 45 CFR §146.136.
- (C) MCO may not apply any cumulative financial requirements for Mental Health or Substance Use Disorder Benefits in a classification (inpatient, outpatient, emergency care, prescription drugs) that accumulates separately from any established for Medical/Surgical Benefits in the same classification as in accordance to 42 CFR § 438.910(c)(3) and the applicable provisions in 45 CFR §146.136.
- (D) MCO may not impose nonquantitative treatment limitation (NQTL) for Mental Health or Substance Use Disorder Benefits in any classification (inpatient, outpatient, emergency care, prescription drugs) unless, under the policies and procedures of MCO as written and in operation, any processes, strategies, evidentiary standards, or other factors used in applying the NQTL to Mental Health or Substance Use Disorder Benefits in the classification are comparable to, and are applied no more stringently than, the processes, strategies, evidentiary standards, or other factors used in applying the limitation for Medical/Surgical Benefits in the classification as in accordance to 42 CFR § 438.910(d)(1) and the applicable provisions in 45 CFR §146.136.
- (E) MCO must use processes, strategies, evidentiary standards, or other factors in determining access to Out-of-Network Providers for Mental Health or Substance Use Disorder Benefits that are comparable to, and applied no more stringently than, the processes, strategies, evidentiary standards, or other factors in determining access to Out-of-Network Providers for Medical/Surgical Benefits in the same classification as in accordance to 42 CFR § 438.910(d)(3) and the applicable provisions in 45 CFR §146.136.

- (F) MCO's prior authorization requirements must comply with the requirements for parity in Mental Health and Substance Use Disorder Benefits in 42 CFR § 438.910(d) and the applicable provisions in 45 CFR §146.136.

Article 4 Benefits, Section 4.3 Mental Health and Substance Use Disorder Benefits 4.3.2 General MHPAEA Requirements notes the following:

- (A) To ensure the full scope of services available to Enrollees complies with the Mental Health and Substance Use Disorder Benefits parity requirements pursuant to 42 CFR § 438 Subpart K, MCO must conduct and submit to STATE a Mental Health or Substance Use Disorder and Medical/Surgical Benefits analysis. The analysis documentation shall be provided in a mutually agreed upon format between STATE and MCO which will be posted to STATE'S Medicaid Website. Such documentation must be updated prior to changes in STATE's ABP.
- (B) After discussion with STATE and in accordance to 42 CFR § 438.3(e)(1)(ii), MCO may cover, in addition to services covered under the State Plan, any services necessary for compliance with the Mental Health and Substance Use Disorder Benefits parity requirements in 42 CFR § 438 Subpart K and only to the extent such services are necessary for MCO to comply with 42 CFR § 438.910. Such services must be consistent with the analysis of the parity compliance conducted by MCO and requires STATE agreement through a contract amendment indicating the scope of service, type, amount, and duration. Terms of any exception with regard to covering a service shall be in compliance with applicable federal or state regulations.

6.0 Financial Requirements and Quantitative Treatment Limits (QTLS)

6.1 Aggregate Lifetime (AL) and Annual Dollar Limits (ADL)

6.1.1 ABP and Fee-For Service Benefit Packages

North Dakota Medicaid does not impose aggregate lifetime (AL), annual dollar limits (ADL), or other cumulative financial limits on any services provided through the FFS and managed care delivery systems, including MH or SUD services. Because North Dakota Medicaid does not impose this type of treatment limitation, North Dakota has determined Medicaid FFS and ABP to be in compliance with the parity regulations for AL/ADLs.

6.2 Financial Requirements

6.2.1 ABP and Fee-for-Service Benefit Packages

North Dakota Medicaid does not use cost sharing such as co-insurance, deductibles, or co-pays in the FFS and managed care delivery systems. Because North Dakota Medicaid does not impose cost sharing

North Dakota has determined Medicaid FFS and ABP to be in compliance with the parity regulation for financial requirements.

6.3 Quantitative Treatment Limits (QTLs)

The MCO does not have QTLs for MH/SUD benefits. Any service identified with a QTL, such as number of visits, can be exceeded if meeting medical necessity, as no hard caps are in place. North Dakota has determined ABP to be in compliance with the parity regulation for financial requirements.

7.0 Non-Quantitative Treatment Limits (NQTLs)

7.1 NQTL Identification and Analysis Process

7.1.1 NQTL Identification

To identify NQTLs, North Dakota reviewed documentation for carved out FFS benefits, as well as documentation from the MCOs; this included reviewing the North Dakota Medicaid State Plan, North Dakota Medicaid provider manuals, and MCO member and provider handbooks. To identify additional NQTLs and collect information about how they are applied in operation, North Dakota created a comprehensive NQTL workbook and distributed it to the MCOs and carved-out FFS programs.

North Dakota participated in a technical assistance call with CMS MH parity subject matter experts to answer questions and focus the NQTL information collection and evaluation process on CMS priorities.

7.1.2 NQTL Evaluation Approach

Once all requested information about NQTLs was received, NQTLs were analyzed for comparability and stringency based on the federal guidance provided in the “Parity Compliance Toolkit.” Based on the guidance provided in the August 22, 2017, webinar, for each NQTL in each classification for each MCO, six questions were addressed to make a compliance determination:

1. What benefits is the NQTL assigned to?
2. Strategy: Why is the NQTL assigned to these services?
3. Evidentiary Standard: What evidence supports the rationale for the assignment?
4. Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the MCO, beneficiary, and provider perspectives).
5. Strategy: How frequently or strictly is the NQTL applied?
6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

After receiving completed workbook from the MCO, the State requested additional information from the MCOs as needed regarding strategies, evidentiary standards, and other factors used in applying NQTLs. North Dakota also held additional meetings with the MCOs to explain the importance of

understanding how the NQTLs are applied in writing and in operation, and address follow-up questions in order to complete the analysis.

7.2 NQTL Classification

Table below lists all the NQTLs applicable to MH/SUD benefits and the benefits to which they apply in a classification. The following sub-section describe how each NQTL applied to MH/SUD benefits meets the parity requirements of comparability and stringency for associated processes, strategies, evidentiary standard, and other factors.

| Standard Type | IP | OP | Prescription Drugs | Emergency Care |
|--|------|----------------|--------------------|----------------|
| Medical management standards | | | | |
| - Medical necessity criteria development | none | none | | none |
| - Prior authorization | none | X-1915(i) only | X | none |
| - Concurrent review | none | none | | none |
| - Retrospective review | none | none | | none |
| - Outlier management | none | none | X | none |
| - Experimental/investigational determinations | none | none | | none |
| - Fail first requirements | none | none | X | none |
| - Exclusions (e.g., based on a failure to complete treatment) | none | none | | none |
| - Medical appropriateness reviews | none | none | X | none |
| - Practice guideline selection/criteria | none | none | | none |
| - Requirements for lower cost therapies to be tried first | none | none | X | none |
| Network admission standards | | | | |
| - Reimbursement rates | | | | |
| - Geographic restrictions | | | | |
| - Specialty requirements or exclusions | | X-1915(i) only | | |
| - Facility type requirements or additional requirements for certain facility types | X | | | |
| - Network tiers | | | | |
| - Out-of-network access standards | X | X | X | |
| Prescription drug benefit & Formulary | | | | |
| Methods for determining usual, customary, and reasonable charges | | | | |

| | | | | |
|---|--|--|---|--|
| Formulary design for prescription drugs | | | X | |
| Prescription drug benefit tiers | | | | |
| Generic vs. brand name | | | X | |
| High cost vs. low cost | | | | |
| Other NQTLs | | | | |
| N/A | | | | |

Abbreviations: IP, inpatient; OP, outpatient; NQTL, non-quantitative treatment limitation; SPA, State Plan Amendment; R&B, Room and Board; PDL, Preferred Drug List; IMD, institutions for mental diseases.

8.0 Non-Quantitative Treatment Limitation (NQTL) Analysis

8.1 Medical Necessity – (Inpatient, Outpatient, Emergency Services) - MCO Sanford

1. What benefits is the NQTL assigned to?

| MH/SUD | M/S |
|---|---|
| <p>Per MCO: Medical Necessity is Health Care Services that are appropriate and necessary as determined by any Participating Provider, in terms or type, frequency, level, setting, and duration, according to the Member’s diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must be consistent with generally accepted standards of medical practice as recognized by Sanford Health Plan, as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and</p> <ul style="list-style-type: none"> a. help restore or maintain the Members health; or b. prevent deterioration of the Member’s condition; or c. prevent the reasonably likely onset of a health problem or detect an incipient problem; or d. not considered an experimental or investigative service. | <p>Per MCO: Medical Necessity is Health Care Services that are appropriate and necessary as determined by any Participating Provider, in terms or type, frequency, level, setting, and duration, according to the Member’s diagnosis or condition, and diagnostic testing and Preventive services. Medically Necessary care must be consistent with generally accepted standards of medical practice as recognized by Sanford Health Plan, as determined by health care Practitioner and/or Providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and</p> <ul style="list-style-type: none"> a. help restore or maintain the Members health; or b. prevent deterioration of the Member’s condition; or c. prevent the reasonably likely onset of a health problem or detect an incipient problem; or d. not considered an experimental or investigative service. |

2. Strategy: Why is the NQTL assigned to these services?

| MH/SUD | M/S |
|--------|-----|
| N/A | N/A |

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

| MH/SUD | M/S |
|--|--|
| The MCO uses MCG (Milliman Care Guidelines) as the evidence-based criteria for all first level medical necessity reviews. If there is insufficient evidence or a case scenario has unusual circumstances or special considerations, a contracted Independent Review Organization (IRO) may be consulted. MCG uses evidence and benchmark data to determine Goal Length of Stay (GLOS) for inpatient stays. | The MCO uses MCG (Milliman Care Guidelines) as the evidence-based criteria used for all first level medical necessity reviews (with the exception of oncology treatment plans). If there is insufficient evidence or a case scenario has unusual circumstances or special considerations, a contracted Independent Review Organization (IRO) may be consulted. MCG uses evidence and benchmark data to determine Goal Length of Stay (GLOS) for inpatient stays. |

4. Processes: Describe the NQTL procedures.

| MH/SUD | M/S |
|--|--|
| The Utilization Management team sets the GLOS based on the clinical situation that is applied to the MCG guideline, and reviews concurrently beyond that date. MCG additionally has extended stay criteria that is utilized in extending inpatient stays beyond the GLOS. Should a member no longer meet criteria, the case is pended for Medical Doctor review; in the event of a denial, consultation with a contracted Independent Review Organization may be utilized. Members that have denied services are given 10 days' notice while inpatient to allow for transition of care. Should the situation change clinically during that time, the case is reviewed again. | The Utilization Management team sets the GLOS based on the clinical situation that is applied to the MCG guideline, and reviews concurrently beyond that date. MCG additionally has extended stay criteria that is utilized in extending inpatient stays beyond the GLOS. Should a member no longer meet criteria, the case is pended for Medical Director review; in the event of a denial, consultation with a contracted Independent Review Organization may be utilized. Members that have denied services are given 10 days' notice while inpatient to allow for transition of care. Should the situation change clinically during that time, the case is reviewed again. For oncology treatment plans, Eviti/Connect is consulted for authorization of chemotherapy and radiation treatment plans. While the health plan retains the final decision, the Eviti authorization tool is the guide for evidence-based medicine standards and providers are given the option to discuss treatment not meeting criteria with an oncologist and are given options for current evidence-based treatment protocols. |

5. Strategy: How frequently or strictly is it applied?

| MH/SUD | M/S |
|---|---|
| The determination of whether a service is medically necessary is made on a case-by-case basis, considering the individual needs of the member, and allowing for consultation with requesting practitioner/providers when appropriate. | The determination of whether a service is medically necessary is made on a case-by-case basis, considering the individual needs of the member, and allowing for consultation with requesting practitioner/providers when appropriate. |

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

| MH/SUD | M/S |
|--|--|
| Utilize nationally recognized criteria set, the MCG, along with the Physician Quality Committee to ensure that standards are applied as appropriate. | Utilize nationally recognized criteria set, the MCG, along with the Physician Quality Committee to ensure that standards are applied as appropriate. |

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standard, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, and strategies, evidentiary standards, and factors used to impose the NQTL and M/S benefits.

8.2 Prior Authorization – Inpatient MCO Sanford

1. What benefits is the NQTL assigned to?

| MH/SUD | M/S |
|---|---|
| Prior authorization, referred to as certification, is a determination by Sanford Health Plan that a prior request for a benefit has been reviewed and, based on the information provided, satisfies Sanford Health Plan’s requirements for Medical Necessity, appropriateness, health care setting, level of care, and effectiveness. | Prior authorization, referred to as certification, is a determination by Sanford Health Plan that a prior request for a benefit has been reviewed and, based on the information provided, satisfies Sanford Health Plan’s requirements for Medical Necessity, appropriateness, health care setting, level of care, and effectiveness. |
| M/SUD Inpatient Services: <ul style="list-style-type: none"> • Inpatient admissions • inpatient rehabilitation • long term acute care • residential treatment • skill nursing facility • swing bed facility | M/S Inpatient Hospital Services: <ul style="list-style-type: none"> • Inpatient admission • inpatient rehabilitation • long term acute care • residential treatment • skill nursing facility • swing bed facility |

| | |
|---|---|
| <ul style="list-style-type: none"> rehabilitation center admissions <p>Medical services for the treatment of an emergency condition, including emergency transportation, crisis intervention/stabilization, and mobile response, are permitted to be delivered in or out of network without obtaining prior authorization.</p> | <ul style="list-style-type: none"> rehabilitation center admissions <p>Medical services for the treatment of an emergency condition, including emergency transportation, crisis intervention/stabilization, and mobile response, are permitted to be delivered in or out of network without obtaining prior authorization.</p> |
|---|---|

2. Strategy: Why is the NQTL assigned to these services?

| MH/SUD | M/S |
|---|---|
| <ul style="list-style-type: none"> Ensure services are provided at an appropriate level of care and place of service. Evaluate service requests that might be approved, potentially denied, or reduced based on medical necessity. Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished and that the services are no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan. | <ul style="list-style-type: none"> Ensure services are provided at an appropriate level of care and place of service. Evaluate service requests that might be approved, potentially denied, or reduced based on medical necessity. Ensure the services to be provided are sufficient in an amount, duration, and scope reasonably expected to achieve the purpose for which the services are furnished and that the services are no less than the amount, duration, or scope for the same services furnished to members under the Medicaid State Plan. |

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

| MH/SUD | M/S |
|--|--|
| Both M/S and MH/SUD health services have the same certification process for approval, as outlined under Section 3, Pg 16-21 in attachment 1. Requested are reviewed by qualified Medical Personnel and compared against Milliman Care Guidelines (MCG) for appropriateness. Coverage is the same across coverage | Both M/S and MH/SUD health services have the same certification process for approval, as outlined under Section 3, Pg 16-21 in attachment 1. Requested are reviewed by qualified Medical Personnel and compared against Milliman Care Guidelines (MCG) for appropriateness. Coverage is the same across coverage |

4. Processes: Describe the NQTL procedures.

| MH/SUD | M/S |
|---|--|
| <ul style="list-style-type: none"> Currently only out of network MH/SUD outpatient services require prior authorization. Network exceptions are based on the following: urgent-emergent situations, complexity of care, continuity | <ul style="list-style-type: none"> Prior-authorization requirements are reviewed, at minimum, annually. Factors that may impact cause for change may include (but are not limited to): industry standard comparisons, external professional |

| | |
|---|--|
| <p>of care, lack of capacity, timely access, and availability.</p> <ul style="list-style-type: none"> • For complexity and continuity of care issues in which out of network care is needed for a chronic condition (for example: behavioral health, oncology, transplant), authorizations are granted on an annual basis to cover the plan year. • Methadone treatment does not require prior authorization. | <p>counsel, utilization reports, provider, and member surveys (feedback).</p> <ul style="list-style-type: none"> • Claims analysis and disruption reports are compiled prior to any changes. Proposed changes inclusive of data reporting are then run through Physician Quality Committee (PQC) and Operations Committee for approval. Should the changes be agreed upon, communication and implementation strategy are composed from there. |
|---|--|

5. Strategy: How frequently or strictly is it applied?

| MH/SUD | M/S |
|--|--|
| <p>A PA is applied through the same process every time. It never deviates once a service is put on the PA list. The PA list is reviewed for new additions or subtractions quarterly by the Physician Quality Committee and is reviewed in its entirety annually.</p> | <p>A PA is applied through the same process every time. It never deviates once a service is put on the PA list. The PA list is reviewed for new additions or subtractions quarterly by the Physician Quality Committee and is reviewed in its entirety annually.</p> |

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

| MH/SUD | M/S |
|--|--|
| <p>SHP applies the best practice of PA review laid out by the National Committee for Quality Assurance (NCQA). NCQA reviews and accredits SHP on the process that supports PA and is what we use as a baseline for all of our lines of business to assure we hold up to the highest scrutiny of member protection.</p> | <p>SHP applies the best practice of PA review laid out by the National Committee for Quality Assurance (NCQA). NCQA reviews and accredits SHP on the process that supports PA and is what we use as a baseline for all of our lines of business to assure we hold up to the highest scrutiny of member protection.</p> |

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standard, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, and strategies, evidentiary standards, and factors used to impose the NQTL and M/S benefits.

8.3 Prior Authorization – Outpatient MCO Sanford

1. What benefits is the NQTL assigned to?

| MH/SUD | M/S |
|--|---|
| <ul style="list-style-type: none"> Applied Behavior Analysis (ABA) <p>Medical services for the treatment of an emergency condition, including emergency transportation, crisis intervention/stabilization, and mobile response, are permitted to be delivered in or out of network without obtaining prior authorization.</p> | <ul style="list-style-type: none"> Alopecia treatment Botox brachytherapy chelation therapy dental anesthesia genetic testing hyperbaric oxygen therapy medical nutrition neuromuscular electrical estimation medically necessary orthodontia photodynamic therapy platelet rich plasma (PRP) radiofrequency ablation varicose vein treatment Abdominoplasty or panniculectomy bariatric surgery blepharoplasty breast implant removal cataract surgery revision or re-implantation breast reconstruction mastectomy endoscopic sinus surgery intrathecal pain pump mammoplasty orthognathic procedures rhinoplasty septoplasty back surgery temporomandibular joint (TMJ) <p>Medical services for the treatment of an emergency condition, including emergency transportation, crisis intervention/stabilization, and mobile response, are permitted to be delivered in or out of network without obtaining prior authorization.</p> |

2. Strategy: Why is the NQTL assigned to these services?

| MH/SUD | M/S |
|--|--|
| <p>Objectives/Strategies</p> <ul style="list-style-type: none"> • Ensure services are provided at an appropriate level of care and place of service. • Evaluate service requests that might be approved, potentially denied, or reduced on the basis of medical necessity criteria. • Ensure the services are in the defied benefits, and are appropriate, timely and cost effective. <p>MCG criteria application, Prior-authorization list, PQC board meeting minutes, Operations Committee board meeting minutes.</p> | <p>Objectives/Strategies</p> <ul style="list-style-type: none"> • Ensure services are provided at an appropriate level of care and place of service. • Evaluate service requests that might be approved, potentially denied, or reduced on the basis of medical necessity criteria. • Ensure the services are in the defied benefits, and are appropriate, timely and cost effective. <p>MCG criteria application, Prior-authorization list, PQC board meeting minutes, Operations Committee board meeting minutes.</p> |

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

| MH/SUD | M/S |
|--|--|
| <ul style="list-style-type: none"> • The MCO adopts evidenced-based guidelines (e.g., MCG) that are updated annually to support prospective, concurrent, and retrospective review, proactive care management, discharge planning, patient education, and quality initiatives. • The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high quality, and cost-effective care. • Both M/S and MH/SUD health services have the same certification process for approval, as outline under Section 3, Pg 16-21 in attachment 1. Requested are reviewed by qualified Medical Personnel and compared against Milliman Care Guidelines (MCG) for appropriateness. Coverage is the same across coverage | <ul style="list-style-type: none"> • The MCO adopts evidenced-based guidelines (e.g., MCG) that are updated annually to support prospective, concurrent, and retrospective review, proactive care management, discharge planning, patient education, and quality initiatives. • The guidelines help assure that prior authorization decisions support care at the appropriate level (outpatient, inpatient, observation, and ambulatory) and place of service to achieve timely, high quality, and cost-effective care. • Both M/S and MH/SUD health services have the same certification process for approval, as outline under Section 3, Pg 16-21 in attachment 1. Requested are reviewed by qualified Medical Personnel and compared against Milliman Care Guidelines (MCG) for appropriateness. Coverage is the same across coverage |

4. Processes: Describe the NQTL procedures.

| MH/SUD | M/S |
|---|---|
| <p>Currently only out of network MH/SUD outpatient services require prior authorization. Network exceptions are based on the following:</p> <ul style="list-style-type: none"> • urgent-emergent situations • complexity of care • continuity of care • lack of capacity • timely access • access and availability <p>For complexity and continuity of care issues in which out of network care is needed for a chronic condition (for example: behavioral health, oncology, transplant), authorizations are granted on an annual basis to cover the plan year. Methadone treatment does not require prior authorization.</p> | <p>Prior-authorization requirements are reviewed, at minimum, annually. Factors that may impact cause for change may include (but are not limited to):</p> <ul style="list-style-type: none"> • industry standard comparisons • external professional counsel • utilization reports • provider and member surveys (feedback) <p>Claims analysis and disruption reports are compiled prior to any changes. Proposed changes inclusive of data reporting are then run through Physician Quality Committee (PQC) and Operations Committee for approval. Should the changes be agreed upon, communication and implementation strategy is composed from there.</p> |

5. Strategy: How frequently or strictly is it applied?

| MH/SUD | M/S |
|--|--|
| <p>A PA is applied through the same process every time. It never deviates once a service is put on the PA list. The PA list is reviewed for new additions or subtractions quarterly by the Physician Quality Committee and is reviewed in its entirety annually.</p> | <p>A PA is applied through the same process every time. It never deviates once a service is put on the PA list. The PA list is reviewed for new additions or subtractions quarterly by the Physician Quality Committee and is reviewed in its entirety annually.</p> |

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

| MH/SUD | M/S |
|--|--|
| <p>SHP applies the best practice of PA review laid out by the National Committee for Quality Assurance (NCQA). NCQA reviews and accredits SHP on the process that supports PA and is what we use as a baseline for all of our lines of business to assure we hold up to the highest scrutiny of member protection.</p> | <p>SHP applies the best practice of PA review laid out by the National Committee for Quality Assurance (NCQA). NCQA reviews and accredits SHP on the process that supports PA and is what we use as a baseline for all of our lines of business to assure we hold up to the highest scrutiny of member protection.</p> |

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standard, and factors used to impose the

NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, and strategies, evidentiary standards, and factors used to impose the NQTL and M/S benefits.

8.4 Concurrent Review – Inpatient and Outpatient MCO Sanford

1. What benefits is the NQTL assigned to?

| MH/SUD | M/S |
|--|--|
| Inpatient: Certification is required for continued treatment. | Inpatient: Certification is required for continued treatment. |
| Outpatient: If Certification is required for initial treatment, certification is required for continued treatment. | Outpatient: If Certification is required for initial treatment, certification is required for continued treatment. |

2. Strategy: Why is the NQTL assigned to these services?

| MH/SUD | M/S |
|---|---|
| Concurrent Review is utilized for medical care, including care for behavioral, mental health, and/or substance use disorders when a request for an extension of an approved ongoing course of treatment over a period of time or number of treatments is warranted. Additional stay days must meet the continued stay review criteria and, if acute levels of care criteria are not met, a decision to certify further treatment must be made at that time. | Concurrent Review is utilized for medical care, including care for behavioral, mental health, and/or substance use disorders when a request for an extension of an approved ongoing course of treatment over a period of time or number of treatments is warranted. Additional stay days must meet the continued stay review criteria and, if acute levels of care criteria are not met, a decision to certify further treatment must be made at that time. |

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

| MH/SUD | M/S |
|---|---|
| Concurrent review is solely based on medical necessity, GLOS, and extended stay review criteria within MCG. Increased frequency of reviews occurs once member is close to discharge date (daily reviews until discharge or transition plan is met). | Concurrent review is solely based on medical necessity, GLOS, and extended stay review criteria within MCG. Increased frequency of reviews occurs once member is close to discharge date (daily reviews until discharge or transition plan is met). |
| Both M/S and MH/SUD health services have the same concurrent review process, as outline under Section 3, Pg 16-21 in attachment 1. Requests are reviewed by qualified Medical Personnel and compared against Milliman Care Guidelines (MCG) | Both M/S and MH/SUD health services have the same concurrent review process, as outline under Section 3, Pg 16-21 in attachment 1. Requests are reviewed by qualified Medical Personnel and compared against Milliman Care Guidelines (MCG) |

| | |
|--|--|
| for appropriateness. Coverage is the same across coverage units. | for appropriateness. Coverage is the same across coverage units. |
|--|--|

4. Processes: Describe the NQTL procedures.

| MH/SUD | M/S |
|---|---|
| <p>If Certification is required for initial treatment, certification is required for continued treatment. When a request for an extension of an approved ongoing course of treatment over a period of time or number of treatments is warranted, additional treatments must meet the continued stay review criteria and, if acute levels of care criteria are not met, a decision to certify further treatment must be made at that time.</p> <p>Both M/S and MH/SUD health services have the same concurrent review process, as outline under Section 3, Pg 16-21 in attachment 1.</p> | <p>If Certification is required for initial treatment, certification is required for continued treatment. When a request for an extension of an approved ongoing course of treatment over a period of time or number of treatments is warranted, additional treatments must meet the continued stay review criteria and, if acute levels of care criteria are not met, a decision to certify further treatment must be made at that time.</p> <p>Both M/S and MH/SUD health services have the same concurrent review process, as outline under Section 3, Pg 16-21 in attachment 1.</p> |

5. Strategy: How frequently or strictly is it applied?

| MH/SUD | M/S |
|--|--|
| <p>Requests are reviewed by qualified Medical Personnel and compared against Milliman Care Guidelines (MCG) for appropriateness. Coverage is the same across coverage units.</p> | <p>Requests are reviewed by qualified Medical Personnel and compared against Milliman Care Guidelines (MCG) for appropriateness. Coverage is the same across coverage units.</p> |

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

| MH/SUD | M/S |
|--|--|
| <p>Average frequency of concurrent review for IP (exclusive of DRGs or case rates): 7 days OP: Upon request/as needed Emergency care: NA</p> | <p>Average frequency of concurrent review for IP (exclusive of DRGs or case rates): 3 days OP: Upon request/as needed Emergency care: NA</p> |

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standard, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, and strategies, evidentiary standards, and factors used to impose the NQTL and M/S benefits.

8.5 Network Admission Requirements- MCO Sanford

1. What benefits is the NQTL assigned to?

| MH/SUD | M/S |
|--|--|
| All benefits that the MCO is contractually obligated to provide. | All benefits that the MCO is contractually obligated to provide. |

2. Strategy: Why is the NQTL assigned to these services?

| MH/SUD | M/S |
|---|---|
| To develop and maintain a robust provider/practitioner network capable of meeting the healthcare needs of the MCO membership in an accessibly, timely and convenient manner, and in accordance with plan contract requirements. | To develop and maintain a robust provider/practitioner network capable of meeting the healthcare needs of the MCO membership in an accessibly, timely and convenient manner, and in accordance with plan contract requirements. |

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

| MH/SUD | M/S |
|--------|-----|
| N/A | N/A |

4. Processes: Describe the NQTL procedures.

| MH/SUD | M/S |
|---|---|
| To be in-network, provider/facility must be located within the state of ND or its contiguous U.S. counties, contracted with Sanford Health Plan and approved credentialing, and enrolled with the state of ND. IHCPs and VAs are always considered in-network, regardless of contracted status. Providers/facilities located outside of ND and its contiguous counties are considered out-of-network and prior authorization is required. | To be in-network, provider/facility must be located within the state of ND or its contiguous U.S. counties, contracted with Sanford Health Plan and approved credentialing, and enrolled with the state of ND. IHCPs and VAs are always considered in-network, regardless of contracted status. Providers/facilities located outside of ND and its contiguous counties are considered out-of-network and prior authorization is required. |

5. Strategy: How frequently or strictly is it applied?

| MH/SUD | M/S |
|--|---------------|
| Facilities excluded: IMDs per federal law for IP services to members ages 21 and older (in writing and in operation) | No exclusions |

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

| MH/SUD | M/S |
|--------|-----|
| N/A | N/A |

7. Compliance Determination

Based on the review of the responses provided in the steps above, it was determined that both as written and in operation, the processes, strategies, evidentiary standard, and factors used to impose the NQTL on MH/SUD benefits are comparable to and applied no more stringently than the processes, and strategies, evidentiary standards, and factors used to impose the NQTL and M/S benefits.

8.6 Practice Guidelines: Emergency Services

An Emergency Medical Condition is the sudden and unexpected onset of a health condition that would lead a prudent layperson acting reasonably and possessing the average knowledge of health and medicine to believe that the absence of immediate medical attention could result in serious impairment to bodily functions or serious dysfunction of a bodily organ or part or would place the person's health, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy. Emergency services are covered at the In-Network cost-sharing level, regardless of Network or service area, and are not disseminated between medical or behavioral health. Both M/S and MH/SUD health services have the same emergency care services, as outlined in Section 4 (c), Pg 38-39 in attachment 1. Coverage is the same across coverage units.

8.7 Coordinated Services Program (CSP)

For the North Dakota Medicaid Expansion population, the MCO administers a Coordinated Service Program (CSP) to improve the continuity and quality of medical care for members while maintaining safety, to improve utilization patterns to control Medicaid expenditures and to provide education on the utilization of services at the appropriate level. Through CSP the MCO has the right and responsibility to restrict a member to a designated health care provider and/or pharmacy if it finds that a member has utilized inpatient, outpatient, emergency care, and/or prescription drugs benefits for M/S and/or MH/SUD at a frequency or amount that is not medically necessary and that exceeds generally accepted medical standards.

The determination to require coordinated services of a member is made by the MCO upon recommendation of medical professionals who have identified utilization patterns through medical audits or referrals that indicate a member may benefit from CSP. In collaboration with the member, the MCO assigns a primary health care provider and/or pharmacy from which the member will receive services including, as applicable, referrals. Members determined eligible and enrolled in the CSP have the right to appeal the CSP decision; if no appeal is received the member will remain in CSP with annual review.

9.0 Prescription Services NQTLs

9.1 Use of a Preferred Drug List

1. What benefits is the NQTL assigned to?

| MH/SUD | M/S |
|---|---|
| The preferred drug list (PDL) only addresses certain drug classes. Some classes of drugs will not be reviewed for preferential agents because of no or limited cost savings. Drugs that have historically been covered by Medicaid and are not listed on the PDL will continue to be covered. | The PDL only addresses certain drug classes. Some classes of drugs will not be reviewed for preferential agents because of no or limited cost savings. Drugs that have historically been covered by Medicaid and are not listed on the PDL will continue to be covered. |

2. Strategy: Why is the NQTL assigned to these services?

| MH/SUD | M/S |
|---|---|
| North Dakota uses a PDL to control costs. | North Dakota uses a PDL to control costs. |

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

| MH/SUD | M/S |
|--|--|
| <p>The North Dakota Drug Use Review (DUR) Board is committed to:</p> <ul style="list-style-type: none"> Objectively recommending drugs for inclusion on the ND PDL that are effective and cost efficient, while providing maximum safety Examining the scientific literature (found in labeling, drug compendia, and peer-reviewed clinical literature) for sound clinical evidence that supports selecting specific drugs to be included on the PDL Ensuring that the PDL provides for medically appropriate drug therapies for use in the general Medicaid population, allowing healthcare providers to care for the majority of their patients without a prior authorization request <p>A vendor provides clinical monographs to validate equal therapeutic effectiveness of drugs in the class and solicits rebates for drugs that are to be preferred.</p> | <p>The North Dakota DUR Board is committed to:</p> <ul style="list-style-type: none"> Objectively recommending drugs for inclusion on the ND PDL that are effective and cost efficient, while providing maximum safety Examining the scientific literature (found in labeling, drug compendia, and peer-reviewed clinical literature) for sound clinical evidence that supports selecting specific drugs to be included on the PDL Ensuring that the PDL provides for medically appropriate drug therapies for use in the general Medicaid population, allowing healthcare providers to care for the majority of their patients without a prior authorization request <p>A vendor provides clinical monographs to validate equal therapeutic effectiveness of drugs in the class and solicits rebates for drugs that are to be preferred.</p> |

4. Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the managed care organization, beneficiary, and provider perspectives).

| MH/SUD | M/S |
|---|---|
| Each drug is reviewed on its clinical merits relative to other medications in the same therapeutic class. Data regarding efficacy, effectiveness, adverse effects, and tolerability is analyzed and compared to other drugs within the therapeutic class. From this analysis, the clinical staff determines an agent’s superiority, equivalency, or inferiority relative to the comparator drugs. | Each drug is reviewed on its clinical merits relative to other medications in the same therapeutic class. Data regarding efficacy, effectiveness, adverse effects, and tolerability is analyzed and compared to other drugs within the therapeutic class. From this analysis, the clinical staff determines an agent’s superiority, equivalency, or inferiority relative to the comparator drugs. |
| After the clinical review, a financial analysis is performed. This analysis incorporates utilization data from the State as well as net drug costs from the manufacturers. With this data, the financial staff determines the fiscal impact of the PDL status (preferred or non-preferred) of each medication. | After the clinical review, a financial analysis is performed. This analysis incorporates utilization data from the State as well as net drug costs from the manufacturers. With this data, the financial staff determines the fiscal impact of the PDL status (preferred or non-preferred) of each medication. |
| Incorporating all this information, recommendations are made for the state DUR Board regarding the PDL status of each medication. After reviewing and discussing these suggestions, the DUR Board makes recommendations to DHS for final decisions. | Incorporating all this information, recommendations are made for the state DUR Board regarding the PDL status of each medication. After reviewing and discussing these suggestions, the DUR Board makes recommendations to DHS for final decisions. |
| Some classes are eliminated when there are no longer savings in the class. | Some classes are eliminated when there are no longer savings in the class. |
| The DUR Board meets four times per year and as necessary to review the PDL and new drugs as they become available. | The DUR Board meets four times per year and as necessary to review the PDL and new drugs as they become available. |

5. Strategy: How frequently or strictly is the NQTL applied?

| MH/SUD | M/S |
|--|--|
| The trial criteria and exceptions for a PDL drug are established based on clinical evidence and the recommendations of the PDL vendor, which are reviewed and approved by the DUR Board. | The trial criteria and exceptions for a PDL drug are established based on clinical evidence and the recommendations of the PDL vendor, which are reviewed and approved by the DUR Board. |
| Therapeutic classes are reviewed annually, at a minimum. Classes may be reviewed more often if new drugs are introduced to the class. | Therapeutic classes are reviewed annually, at a minimum. Classes may be reviewed more often if new drugs are introduced to the class. |
| The PDL is reviewed in total annually and updated quarterly. | The PDL is reviewed in total annually and updated quarterly. |

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

| MH/SUD | M/S |
|---|---|
| Per ND Century code 50-24.6, DHS is prohibited from prior authorizing antidepressants, antipsychotics, anticonvulsants, and stimulants used for ADHD except in extremely specific circumstances (extreme outlier prescriber or when the patient is on 5 or more psych medications). Neither of the allowed exceptions has been operationalized, therefore, all psych medications are covered without prior authorization. | Per ND Century code 50-24.6, all prior authorization and preferred drug list activities are performed as allowed under state (and federal) law. |

9.2 Drugs on PDL must be tried first (Step therapy/fail first)

1. What benefits is the NQTL assigned to?

| MH/SUD | M/S |
|---|---|
| Preferred drug list is available at: http://hidesigns.com/ndmedicaid/pdl/2021.html | Preferred drug list is available at: http://hidesigns.com/ndmedicaid/pdl/2021.html |

2. Strategy: Why is the NQTL assigned to these services?

| MH/SUD | M/S |
|--|--|
| North Dakota uses a PDL, to control costs. | North Dakota uses a PDL, to control costs. |

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

| MH/SUD | M/S |
|--|--|
| Ensure medically appropriate drug therapies for use in the general Medicaid population that are effective and cost efficient, while providing maximum safety and allowing healthcare providers to care for the majority of their patients without a prior authorization request. | Ensure medically appropriate drug therapies for use in the general Medicaid population that are effective and cost efficient, while providing maximum safety and allowing healthcare providers to care for the majority of their patients without a prior authorization request. |

4. Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the managed care organization, beneficiary, and provider perspectives).

| MH/SUD | M/S |
|--|--|
| Processes for applying the NQTL are the same for all covered prescription drugs; edits are applied | Processes for applying the NQTL are the same for all covered prescription drugs; edits are applied |

| | |
|--|--|
| at the point of sale when the prescription is adjudicated. | at the point of sale when the prescription is adjudicated. |
| Non-PDL prescriptions are denied at the point of sale if criteria are not met. | Non-PDL prescriptions are denied at the point of sale if criteria are not met. |

5. Strategy: How frequently or strictly is the NQTL applied?

| MH/SUD | M/S |
|--|--|
| System edits are applied at the point of sale every time a prescription is adjudicated. | System edits are applied at the point of sale every time a prescription is adjudicated. |
| The clinical pharmacists at the state’s pharmacy PA vendor have discretion to issue a PA for a non-PDL drug if a clinical justification is provided by the prescriber. | The clinical pharmacists at the state’s pharmacy PA vendor have discretion to issue a PA for a non-PDL drug if a clinical justification is provided by the prescriber. |

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

| MH/SUD | M/S |
|---|---|
| Per ND Century code 50-24.6, DHS is prohibited from prior authorizing antidepressants, antipsychotics, anticonvulsants, and stimulants used for ADHD except in extremely specific circumstances (extreme outlier prescriber or when the patient is on 5 or more psych medications). Neither of the allowed exceptions has been operationalized, therefore, all psych medications are covered without prior authorization. | Per ND Century code 50-24.6, all prior authorization and preferred drug list activities are performed as allowed under state (and federal) law. |

9.3 Prior Authorization

1. What benefits is the NQTL assigned to?

| MH/SUD | M/S |
|--|--|
| All non-preferred drugs or drugs requiring a PA that are in therapeutic classes not included on the PDL. | All non-preferred drugs or drugs requiring a PA that are in therapeutic classes not included on the PDL. |

2. Strategy: Why is the NQTL assigned to these services?

| MH/SUD | M/S |
|---|---|
| Non-PDL drugs are assigned PA because of the potential for adverse effects, misuse, or high cost. | Non-PDL drugs are assigned PA because of the potential for adverse effects, misuse, or high cost. |

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

| MH/SUD | M/S |
|---|---|
| Drugs or drug classes that are reviewed and found to be inappropriately utilized or have significant safety concerns are deemed candidates for PA. These reviews are considered by the DUR Board and appropriate criteria for approval are determined by them, with input from medical and pharmacy providers, drug manufacturers, and other experts. | Drugs or drug classes that are reviewed and found to be inappropriately utilized or have significant safety concerns are deemed candidates for PA. These reviews are considered by the DUR Board and appropriate criteria for approval are determined by them, with input from medical and pharmacy providers, drug manufacturers, and other experts. |
| ND Medicaid PA criteria are developed by the PA vendor staff, with the assistance of the pharmacists on staff with ND Medicaid and are reviewed by the State's Medicaid DUR Board. | ND Medicaid PA criteria are developed by the PA vendor staff, with the assistance of the pharmacists on staff with ND Medicaid and are reviewed by the State's Medicaid DUR Board. |

4. Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the managed care organization, beneficiary, and provider perspectives).

| MH/SUD | M/S |
|---|---|
| The PA process requires that non-preferred drugs meet specified criteria in order to be reimbursed. | The PA process requires that non-preferred drugs meet specified criteria in order to be reimbursed. |
| PA requests may be made by telephone, fax, or mail. | PA requests may be made by telephone, fax, or mail. |
| Clinical pharmacists employed by the PA vendor have discretion for approval and usually obtain more clinical information from the prescriber. | Clinical pharmacists employed by the PA vendor have discretion for approval and usually obtain more clinical information from the prescriber. |
| A five-day emergency supply of prior-authorized drugs can be dispensed by a pharmacy until authorization is completed. | A five-day emergency supply of prior-authorized drugs can be dispensed by a pharmacy until authorization is completed. |
| If PA is needed and not obtained, or PA is not approved, the prescription is not filled for the member. | If PA is needed and not obtained, or PA is not approved, the prescription is not filled for the member. |

5. Strategy: How frequently or strictly is the NQTL applied?

| MH/SUD | M/S |
|---|---|
| Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance. | Prior authorization for a non-preferred agent in any category will be given only if there has been a trial of the preferred brand/generic equivalent or preferred formulation of the active ingredient, at a therapeutic dose, that resulted in a partial response with a documented intolerance. |
| Trial criteria, PA criteria, and duration of PA are determined by the DUR Board with clinical | Trial criteria, PA criteria, and duration of PA are determined by the DUR Board with clinical |

| | |
|---|---|
| recommendations provided by ND Medicaid's vendor. | recommendations provided by ND Medicaid's vendor. |
|---|---|

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

| MH/SUD | M/S |
|---|---|
| Per ND Century code 50-24.6, DHS is prohibited from prior authorizing antidepressants, antipsychotics, anticonvulsants, and stimulants used for ADHD except in extremely specific circumstances (extreme outlier prescriber or when the patient is on 5 or more psych medications). Neither of the allowed exceptions has been operationalized, therefore, all psych medications are covered without prior authorization. | Per ND Century code 50-24.6, all prior authorization and preferred drug list activities are performed as allowed under state (and federal) law. |

9.4 Prospective Review

1. What benefits is the NQTL assigned to?

| MH/SUD | M/S |
|--------------------|--------------------|
| All prescriptions. | All prescriptions. |

2. Strategy: Why is the NQTL assigned to these services?

| MH/SUD | M/S |
|--|--|
| Potential for adverse effects and inappropriate use, and cost containment. | Potential for adverse effects and inappropriate use, and cost containment. |

3. Evidentiary Standard: What evidence supports the rationale for the assignment?

| MH/SUD | M/S |
|--|--|
| The DUR Board and state staff review the criteria regularly using FDBHealth, DrugDex (Micromedex), and other compendia as outlined in SSA subsection 1927. | The DUR Board and state staff review the criteria regularly using FDBHealth, DrugDex (Micromedex), and other compendia as outlined in SSA subsection 1927. |

4. Processes: Describe the NQTL procedures (e.g., steps, timelines, and requirements from the managed care organization, beneficiary, and provider perspectives).

| MH/SUD | M/S |
|---|---|
| Processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing. | Processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies DUR edits to pharmacy claims as they are processing. |
| Pharmacists filling the prescriptions and the pharmacy staff at ND Medicaid are responsible for applying the policies. | Pharmacists filling the prescriptions and the pharmacy staff at ND Medicaid are responsible for applying the policies. |
| Claims deny for early refills, therapeutic duplications, ingredient duplications, or inappropriate dosages; or require additional review if they are flagged for these edits. | Claims deny for early refills, therapeutic duplications, ingredient duplications, or inappropriate dosages; or require additional review if they are flagged for these edits. |
| Clinical personnel have discretion to make exceptions to the policy depending on the clinical information provided by the prescriber. | Clinical personnel have discretion to make exceptions to the policy depending on the clinical information provided by the prescriber. |

5. Strategy: How frequently or strictly is the NQTL applied?

| MH/SUD | M/S |
|--|--|
| Processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies drug utilization review (DUR) edits to pharmacy claims as they are processing. | Processes for applying the NQTL are the same for all covered prescription drugs; the claims processing system applies drug utilization review (DUR) edits to pharmacy claims as they are processing. |

6. Evidentiary Standard: What standard supports the frequency or rigor with which it is applied?

| MH/SUD | M/S |
|---------------------------------|---------------------------------|
| Required by federal regulation. | Required by federal regulation. |

10.0 Availability of Information

10.1 Criteria for Medical Necessity Determination

The Medicaid parity rule requires that the criteria for medical necessity determinations for MH/SUD benefits must be made available to beneficiaries (MCO enrollees and potential enrollees with a managed care entity) and affected Medicaid providers upon request.

10.1.1 FFS Benefits

ND Medicaid makes the criteria for medical necessity determination for FFS MH/SUD benefits available to beneficiaries and affected providers upon request.

10.1.2 MCOs

The following excerpt from ND Medicaid's Calendar Year 2021 MCO contract, Section 7.3 Required Content of Notice of Adverse Benefit Determination, sub-section 7.3.1 demonstrates compliance with the availability of information requirement.

- (A) MCO's Notice of Adverse Benefit Determination to an Enrollee shall be in writing and meet the language and format requirements outlined in Article 3 to ensure ease of understanding.
- (B) All written Notices of Adverse Benefit Determination required by this contract shall explain the following:
 - (1) The Adverse Benefit Determination MCO has taken or intends to take;
 - (2) The reason for the Adverse Benefit Determination;
 - (3) The date the Adverse Benefit Determination will become effective when the Adverse Benefit Determination is to terminate, suspend, or reduce a previously authorized Covered Service;
 - (4) The Enrollee's or Provider's right to file an Appeal of the Adverse Benefit Determination with MCO;
 - (5) The procedures for filing an Appeal;
 - (6) The circumstances under which expedited resolution of the Appeal is available and how to request an expedited Appeal resolution;
 - (7) The Enrollee's right to have disputed services continue, pending resolution of the Appeal of an Adverse Benefit Determination to terminate, suspend, or reduce a previously authorized course of treatment, that was ordered by an authorized Provider;
 - (8) How to request that the disputed services be continued and the circumstances under which the Enrollee may be required to pay the cost of these services if the Appeal decision is adverse to the Enrollee, to the extent that they were furnished solely because of this contract requirement in accordance with 42 CFR §§ 438.420, 438.404(b)(6), and 431.230(b); and
 - (9) The following timeframe for filing an Appeal. Following the receipt of a notification of an Adverse Benefit Determination by MCO, Enrollee has 60 calendar days from the date of the Adverse Benefit Action notice in which to file a request for an Appeal to MCO.

10.2 Reason for Denial of Payment

The Medicaid parity rule requires that the reason for any denial of reimbursement or payment for MH/SUD benefits must be made available to the beneficiary, including the applicable medical necessity

criteria as applied to that enrollee. This should include providing any processes, strategies, or evidentiary standards used in applying the medical necessity criteria to the enrollee.

10.2.1 FFS Benefits

ND Medicaid makes the reason for any denial of reimbursement or payment for a FFS MH/SUD benefit available to the beneficiary.

10.2.2 MCOs

The following excerpt from ND Medicaid's Calendar Year 2021 MCO contract, Section 7.3 Required Content of Notice of Adverse Benefit Determination, sub-section 7.3.1 demonstrates compliance with the availability of information requirement which includes reason for denial of payment.

- (A) MCO's Notice of Adverse Benefit Determination to an Enrollee shall be in writing and meet the language and format requirements outlined in Article 3 to ensure ease of understanding.
- (B) All written Notices of Adverse Benefit Determination required by this contract shall explain the following:
 - (1) The Adverse Benefit Determination MCO has taken or intends to take;
 - (2) The reason for the Adverse Benefit Determination;
 - (3) The date the Adverse Benefit Determination will become effective when the Adverse Benefit Determination is to terminate, suspend, or reduce a previously authorized Covered Service;
 - (4) The Enrollee's or Provider's right to file an Appeal of the Adverse Benefit Determination with MCO;
 - (5) The procedures for filing an Appeal;
 - (6) The circumstances under which expedited resolution of the Appeal is available and how to request an expedited Appeal resolution;
 - (7) The Enrollee's right to have disputed services continue, pending resolution of the Appeal of an Adverse Benefit Determination to terminate, suspend, or reduce a previously authorized course of treatment, that was ordered by an authorized Provider;
 - (8) How to request that the disputed services be continued and the circumstances under which the Enrollee may be required to pay the cost of these services if the Appeal decision is adverse to the Enrollee, to the extent that they were furnished solely because of this contract requirement in accordance with 42 CFR §§ 438.420, 438.404(b)(6), and 431.230(b); and
 - (9) The following timeframe for filing an Appeal. Following the receipt of a notification of an Adverse Benefit Determination by MCO, Enrollee has 60 calendar days from the date of the Adverse Benefit Action notice in which to file a request for an Appeal to MCO.

Mental Health (MH) Parity Summary

1.0 Summary MH Parity Overview

1.1 Medicaid Mental Health Parity Final Rule Background

On March 29, 2016, CMS issues a Final Rule applying the MHPAEA parity requirements to coverage offered by Medicaid MCO,CHIP, and Medicaid benchmark and benchmark-equivalent (referred to as ABPs in the Final Rule). The Final Rule explains roles and responsibilities for determining and monitoring compliance, as well as parity requirements.

1.2 General Parity Requirement

The MHPAEA requires insurers and plans to guarantee that all FR (ie, deductible, co-pays), as well as caps and limitation on benefits, be no more restrictive for MH and SUD services then for medical surgical (M/S) counterparts under the same plan. Specific MHPAEA requirements include aggregate lifetime and annual dollar limits (AL/ADL); FRs and QTLs; NQTLs; and the availability of information, including the reason for denial of services.

This document is intended to fulfill the Final Rule requirement that states provide documentation of compliance with Final Rule requirements to the general public and post the information on their State Medicaid Website.

2.0 Parity Analysis Approach

2.1 Benefit Package and Delivery Systems

The Medicaid benefit package is for all Medicaid members. It can be delivered to members by FFS, MCO or a mixture of both. ND currently only has one MCO as part of it managed care program, Sanford Health Plan. SHP covers all the expansion Medicaid members. Pharmacy benefits are carved out of the MCO's responsibility and are covered b FFS.

2.2 Methodology

To determine compliance, NDDHS followed the process provided by CMS in the January 17,2017, "parity Compliance Toolkit Applying mental health, and Substance Use Disorder Parity Requirements to Medicaid."

The Department also met with the FS program managers and representatives from the MCO to review policies and procedures to determine compliance.

2.2.1 Definitions

The following definitions were used by the Department to group and classify benefits for the parity analysis.

| Classification | Definition |
|--|--|
| Medical/Surgical (M/S) Benefits | Benefits for items or services for medical conditions or surgical procedures, as defined by the State and in accordance with the applicable federal and State law, but do not include MH or SUD benefits. |
| Mental Health (MH) Benefits and Substance Use Disorder (SUD) Benefits | Mental health and SUD benefits means benefits with respect to items or services for mental health conditions or SUD conditions, as defined under the terms of the plan or health insurance coverage and in accordance with applicable Federal and State law. |
| Inpatient | Services provided to a patient who is admitted into a hospital, acute care setting, psychiatric health facility or long-term facility under the recommendation of a physician. Inpatient services include all treatments, pharmaceutical, equipment, test, and procedures provided during an inpatient treatment episode. |
| Outpatient | Services provided to a patient who evaluated or treated in an outpatient clinic, outpatient hospital or community-based setting. Outpatient services include all treatments, equipment, tests, procedures, and clinician-administered pharmaceuticals provided during an outpatient treatment episode. |
| Emergency Care | Covered services or medications that are furnished by a qualified provider and are needed to evaluate or stabilize and emergency medical condition delivered in an emergency department (ED). |
| Prescription Drugs | Simple or compounded substance or mixture of substances prescribed for the cure, mitigation or prevention of a disease or health maintenance. Prescription drugs are dispensed by a pharmacist who works in a retail or mail order pharmacy or through substance use disorder medication-assisted treatment. Prescription drug coverage is |

not provided by SHP. FFS ND Medicaid provides outpatient prescription drug coverage.

3.0 Parity Analysis Findings

3.1 AL/ADLs

ND Medicaid does not impose AL or ADLs therefore it is determined the ND Medicaid is in compliance with the parity regulations for AL/ADLs.

3.2 FRs

ND Medicaid does not use cost sharing such as co-insurance, deductibles, or co-pays in the FFS or managed care delivery systems. Therefore, ND Medicaid is in compliance with the parity regulations for financial requirements.

3.3 QTLs

There are no services for MH/SUD that have QTLs assigned. Therefore, ND Medicaid is in compliance with the parity regulations for QTLs.

3.4 NQTLs

ND Medicaid has determined the applicable FFS programs and pharmacy benefits to be in compliance with the parity regulations for NQTLs. The MCO is in compliance with the parity regulations for NQTLs.

3.5 Availability of Information

ND Medicaid has determined the applicable FFS programs and pharmacy benefits, as well as the MCO, to be in compliance with the parity regulations for the availability of information.

North Dakota Medicaid Expansion

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How to Contact Us

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

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300 Cherapa Place, Suite 201
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Sioux Falls, SD 57109
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Free Help in Other Languages

This Certificate of Coverage replaces any prior policies you may have had. We hope you find it easy to read and helpful in answering your health coverage questions. It is the legal document representing your coverage, so please keep it in a safe place where you can easily find it. If you have any questions, for example, about your benefits, this document, or how this Plan pays for your care, please call us toll-free at (855) 305-5060 | TTY: 711.

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

English

This Notice has Important Information. This notice has important information about your application or coverage through Sanford Health Plan. Look for key dates in this notice. You may need to take action by certain deadlines to keep your health coverage or help with costs. You have the right to get this information and help in your language at no cost. Call 1-855-305-5060 (toll-free) | TTY: 711 (*toll-free*). For assistance in a language other than English, call 1-800-892-0675 (toll-free).

Spanish

Este Aviso contiene información importante. Este aviso contiene información importante acerca de su solicitud o cobertura a través de Sanford Health Plan. Preste atención a las fechas clave que contiene este aviso. Es posible que deba tomar alguna medida antes de determinadas fechas para mantener su cobertura médica o ayuda con los costos. Usted tiene derecho a recibir esta información y ayuda en su idioma sin costo alguno. Llame al 1-800-892-0675 | TTY: 711.

German

Diese Benachrichtigung enthält wichtige Informationen. Diese Benachrichtigung enthält wichtige Informationen bezüglich Ihres Antrags auf Krankenversicherungsschutz durch Sanford Health Plan. Suchen Sie nach wichtigen Terminen in dieser Benachrichtigung. Sie könnten bis zu bestimmten Stichtagen handeln müssen, um Ihren Krankenversicherungsschutz oder Hilfe mit den Kosten zu behalten. Sie haben das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Rufen Sie an unter 1-800-892-0675 | TTY: 711.

Chinese

本通知有重要的訊息。 本通知有關於您透過 插入 Sanford Health Plan 項目的名稱 Sanford Health Plan 提交的申請或保險的重要訊息。請留意本通知內的重要日期。您可能需要在截止日期之前採取行動，以保留您的健康保險或者費用補貼。您有權利免費以您的母語得到本訊息和幫助。請撥電話 [在此插入數字 1-800-892-0675 | TTY: 711.]

Cushite

Beeksisni kun odeeffannoo barbaachisaa qaba. Beeksisti kun sagantaa yookan karaa Sanford Health Plan tiin tajaajila keessan ilaalchisee odeeffannoo barbaachisaa qaba. Guyyaawwan murteessaa ta'an beeksisa kana keessatti ilaalaa. Tarii kaffaltiidhaan deeggaramuuf yookan tajaajila fayyaa keessaniif guyyaa dhumaa irratti wanti raawwattan jiraachuu danda'a. Kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabaattu. Lakkoofsa bilbilaa 1-800-892-0675 | TTY: 711 ti bilbilaa.

Vietnamese

Thông báo này cung cấp thông tin quan trọng. Thông báo này có thông tin quan trọng bàn về đơn nộp hoặc hợp đồng bảo hiểm qua chương trình Sanford Health Plan. Xin xem ngày then chốt trong thông báo này. Quý vị có thể phải thực hiện theo thông báo đúng trong thời hạn để duy trì bảo hiểm sức khỏe hoặc được trợ giúp thêm về chi phí. Quý vị có quyền được biết thông tin này và được trợ giúp bằng ngôn ngữ của mình miễn phí. Xin gọi số 1-800-892-0675 | TTY: 711.

Bantu

Iyi notice ifise akamaro k'ingenzi. Iyi notice ifise akamaro kingene utegerezwa gusaba canke ivyerekeye Sanford Health Plan, ucuraba ko ibikenewe kuriyi notice, ushobora gufata umwanzuro ukungene wokurikirana ubuzima bwawe uburihiye. Kandi ukongera kugira uburenganzira bwo kwigenga kuronka amakuru n'ubufasha mu rurimi gwawe atacyo utanze. Hamagara 1-800-892-0675 | TTY: 711.

Arabic

تماه تاملوعم راعشلا اذه يوحي. للاخ نم تيطغتلا لع لوصحلل كبلط صوصخب تمهم تاملوعم راعشلا اذه يوحي .Sanford Health Plan راعشلا اذه يف تماهلا خير او تال نع ثحبا. عغد يف تدعاسملل وا تبحصلا كتيطغت لع ظافحل قتييم خيراوت يف ءارجا ذاختلا جاتحت بق فيلاكتلا. تفلكت يا نود نم كتغلب تدعاسملو تاملوعملا لع روصحلا يف قحلا كل .ب لصتا .TTY: 711 | 1-800-892-0675

Swahili

Ilani hii ina Taarifa Muhimu. Ilani hii ina taarifa muhimu kuhusu maombi yako au chanjo kupitia Sanford Health Plan. Angalia kwa ajili ya tarehe muhimu katika ilani hii. Waweza pia hitajika kuchukua hatua katika muda ulio pangwa fulani ili uweze ku hifadhi bima yako ya afya au msaada wa gharama zake. Una haki ya kupata habari hii na msaada kwa lugha yako bila gharama. Piga nambari hii: 1-800-892-0675 | TTY: 711.

Russian

Настоящее уведомление содержит важную информацию. Это уведомление содержит важную информацию о вашем заявлении или страховом покрытии через Sanford Health Plan. Посмотрите на ключевые даты в настоящем уведомлении. Вам, возможно, потребуется принять меры к определенным предельным срокам для сохранения страхового покрытия или помощи с расходами. Вы имеете право на бесплатное получение этой информации и помощь на вашем языке. Звоните по телефону 1-800-892-0675 | TTY: 711.

Japanese

この通知には重要な情報が含まれています。この通知には、Sanford Health Plan の申請または補償範囲に関する重要な情報が含まれています。この通知に記載されている重要な日付をご確認ください。健康保険や有料サポートを維持するには、特定の期日までに行動を取らなければならない場合があります。ご希望の言語による情報とサポートが無料で提供されます。1-800-892-0675 | TTY: 711までお電話ください。

Nepali

यो सूचनामा महत्त्वपूर्ण जानकारी छ । यो सूचनामा तपाईंको आवेगिन वा Sanford Health Plan का माध्यमबाट प्राप्त हुने सुदविबारे महत्त्वपूर्ण जानकारी छ । यो सूचनामा भएका महत्त्वपूर्ण दमदतहरू ख्याल िनुहोस् । तपाईंले पाइरहेको स्वास्थ्य दबमा पाइरहन वा तपाईंको खचुको भुक्तानीमा सहायता पाउन केही समय-सीमामा काम-कारवाही िनुपने हुनसक्छ । तपाईंले यो जानकारी र सहायता आफ्नो मातृभाषामा दनःशुल्क पाउनु तपाईंको अधिकार हो । 1-800-892-0675 | TTY: 711मा फोन िनुहोस् ।

French

Cet avis a d'importantes informations. Cet avis a d'importantes informations sur votre demande ou la couverture par l'intermédiaire de Sanford Health Plan. Rechercher les dates clés dans le présent avis. Vous devrez peut-être prendre des mesures par certains délais pour maintenir votre couverture de santé ou d'aide avec les coûts. Vous avez le droit d'obtenir cette information et de l'aide dans votre langue à aucun coût. Appelez 1-800-892-0675 | TTY: 711.

Korean

본 통지서에는 중요한 정보가 들어 있습니다. 즉 이 통지서는 귀하의 신청에 관하여 그리고 Sanford Health Plan 을 통한 커버리지에 관한 정보를 포함하고 있습니다. 본 통지서에서 핵심이 되는 날짜들을 찾으십시오. 귀하는 귀하의 건강 커버리지를 계속 유지하거나 비용을 절감하기 위해서 일정한 마감일까지 조치를 취해야 할 필요가 있을 수 있습니다. 귀하는 이러한 정보와 도움을 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 1-800-892-0675 | TTY: 711 로 전화하십시오.

Tagalog

Ang Paunawa na ito ay naglalaman ng mahalagang impormasyon. Ang paunawa na ito ay naglalaman ng mahalagang impormasyon tungkol sa iyong aplikasyon o pagsakop sa pamamagitan ng Sanford Health Plan. Tingnan ang mga mahalagang petsa dito sa paunawa. Maaring mangailangan ka na magsagawa ng hakbang sa ilang mga itinakdang panahon upang mapanatili ang iyong pagsakop sa kalusugan na walang gastos. May karapatan ka na makakuha ng ganitong impormasyon at tulong sa iyong wika ng walang gastos. Tumawag sa 1-800-892-0675 | TTY: 711.

Norwegian

Denne kunngjøringen har viktig informasjon. Kunngjøringen inneholder viktig informasjon om programmet eller dekning gjennom Sanford Health Plan. Se etter viktige datoer i denne kunngjøringen. Du må kanskje ta affære ved visse frister for å beholde helsedekning eller økonomisk bistand. Du har rett til å få denne informasjonen og hjelp i ditt språk uten kostnad. Ring 1-800-892-0675 | TTY: 711.

Privacy and HIPAA Disclosure Notices

Sanford Health Plan's Use and Disclosure of Your Personal Health Information

Sanford Health Plan has an agreement with the State of North Dakota (ND) that allows it to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in this Plan, you agree that Sanford Health Plan may obtain, use and release all records about you, that it needs to administer the Plan or to perform any functions authorized or permitted by law. You further direct all persons to release all records to us about you that it needs in order to administer claims under the Plan.

Sanford Health Plan Notice of Privacy Practices

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

This Notice applies to Sanford Health Plan [herein known as “we”/“us”/“our”]. If you have questions about this Notice, please contact Customer Service at (855) 305-5060 (*toll-free*) | TTY: 711.

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

HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION

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

- 1. Help manage the health care treatment you receive:** We can use your health information and share it with professionals who are treating you. For example, a doctor may send us information about your diagnosis and treatment plan so we can arrange additional services.
- 2. Pay for your health services:** We can use and disclose your health information as we pay for your health services. For example, we share information about you with your Primary Care Provider and/or Practitioner to coordinate payment for those services.
- 3. For our health care operations:** We may use and share your health information for our day-to-day operations, to improve our services, and contact you when necessary. For example, we use health information about you to develop better services for you. We are not allowed to use genetic information to decide whether we will give you coverage and the price of that coverage. This does not apply to long-term care plans.
- 4. Administer your plan:** We may disclose your health information to your health plan sponsor for plan administration. For example, your company contracts with us to provide a health plan, and we provide your company with certain statistics to explain the premiums we charge.

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

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

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

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

We may contact you in the following situations:

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

YOUR RIGHTS THAT APPLY TO YOUR HEALTH INFORMATION

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

- **Get a copy of your health and claims records:** You can ask to see or get a paper or electronic copy of your health and claims records and other health information we have about you. We will provide a copy or summary to you usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- **Ask us to correct your health and claims records:** You can ask us to correct health information that you think is incorrect or incomplete. We may deny your request, but we'll tell you why in writing. These requests should be submitted in writing to the contact listed below.
- **Request confidential communications:** You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. Reasonable requests will be approved. We must say "yes" if you tell us you would be in danger if we do not.
- **Ask us to limit what we use or share:** You can ask us to restrict how we share your health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.
- **Get a list of those with whom we've shared information:** You can ask for a list (accounting) of the times we've shared your health information for six (6) years prior, who we've shared it with, and why. We will include all disclosures except for those about your treatment, payment, and our health care operations, and certain other disclosures (such as those you asked us to make). We will provide one (1) accounting a year for free, but we will charge a reasonable cost-based fee if you ask for another within twelve (12) months.
- **Get a copy of this privacy notice:** You can ask for a paper copy of this Notice at any time, even if you have agreed to receive it electronically. We will provide you with a paper copy promptly.
- **Choose someone to act for you:** If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- **File a complaint if you feel your rights are violated:** You can complain to the U.S. Department of Health and Human Services Office for Civil Rights if you feel we have violated your rights. We can provide you with their address. You can also file a complaint with us by using the contact information below. We will not retaliate against you for filing a complaint.
- **Contact Information:**
Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110
(855) 305-5060 (*toll-free*) | TTY: 711

OUR RESPONSIBILITIES REGARDING YOUR HEALTH INFORMATION

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

CHANGES TO THIS NOTICE

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

EFFECTIVE DATE

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

NOTICE OF ORGANIZED HEALTH CARE ARRANGEMENT FOR SANFORD HEALTH PLAN

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

Introduction

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

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

| | |
|--|---|
| Physical Address | Mailing Address |
| Sanford Health Plan 300 Cherapa Place, Suite 201 Sioux Falls, SD 57103 | Sanford Health Plan PO Box 91110 Sioux Falls, SD 57109-1110 |
| Customer Service | Free Translation Services |
| (855) 305-5060 (<i>toll-free</i>) or TTY: 711 | (800) 892-0675 (<i>toll-free</i>) |
| Sanford Health Plan Network Provider Locator | Prior Authorization (Certification) |
| If you need to locate a Provider in your area, call: (855) 305-5060 (<i>toll-free</i>) TTY: 711 | The Facility, your Provider, or you should call: (855) 276-7214 (<i>toll-free</i>) or TTY: 711 |
| Care/Case Management | Transportation |
| (888) 315-0884 (<i>toll-free</i>) or TTY: 711 | (800) 236-4907 (<i>toll-free</i>) or TTY: 711 |
| Appeals and Complaints Department | Website |
| (877) 652-8544 (<i>toll-free</i>) or TTY: 711 | www.sanfordhealthplan.com |
| | mySanfordHealthPlan Member Portal |
| | www.sanfordhealthplan.com/memberlogin |
| Prescription Drugs | |
| Retail outpatient pharmacy benefits are administered by the North Dakota Department of Human Services (DHS), and not by Sanford Health Plan. You will have a different ID card for use when filling prescriptions, starting 01/01/2020. If you have questions about your pharmacy benefits, please call ND DHS at 1-800-755-2604 TTY: 711 | |

Member Rights

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

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

10. When Members do not speak or understand the predominant language of the community, the Plan will make reasonable efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
11. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and easy to read.
12. Members have the right to a clear grievance and Appeal process for complaints and comments and to have their issues resolved in a timely manner.
13. Members have the right to Appeal any decision regarding medical necessity made by the Plan and its Providers.
14. Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
15. Members have the right to receive information about the organization, its services and Providers and Members' rights and responsibilities, in accordance with 42 CFR §438.10.
16. The right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, as specified in other federal regulations on the use of restraints and seclusion.
17. Members have the right to be free to exercise all rights and that by exercising those rights; they shall not be adversely treated by the State, the Plan, and/or its Network Providers.

Member Responsibilities

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

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

Fraud

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

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

As a Member, you must:

1. File accurate claims. If someone else files a claim on your behalf, you should review the form before you sign it;
2. Review any Explanation of Benefits (EOB) when you get them. Make certain that benefits have been paid correctly based on your knowledge of the expenses incurred and the services rendered;
3. Never allow another person to seek medical treatment under your identity. If your ID card is lost, you should report the loss to Sanford Health Plan immediately; and
4. Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.

If you are concerned about any of the charges that appear on a bill, Explanation of Benefits (EOB), form, or other statement; or if you know of or suspect any illegal activity, call Sanford Health Plan toll-free at (855) 305-5060 | TTY: 711. All calls are strictly confidential.

Coordinated Services Program (CSP)

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

The following criteria will be used to determine if the CSP is appropriate:

- a. Seriousness of incorrect, improper or excessive utilization of services;
- b. Historical utilization of the Member; and
- c. Availability of a coordinated services physician.

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

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

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

Authorized Certificate of Coverage Changes

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

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

Governing Law

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

Incontestability

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

Physical Examination

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

Legal Action

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

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

Disclosure Statement

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

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

Nondiscrimination Policy

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

Notice of Nondiscrimination

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

Sanford Health Plan:

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

If you need these services, tell us. If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance (complaint) with the Plan's Compliance Officer, who serves as the Nondiscrimination Coordinator.

Call (855) 305-5060 (toll-free) | TTY: 711 or write PO Box 91110, Sioux Falls, SD 57109-1110. You can file a grievance in person or by mail or phone. You may also submit information via your mySanfordHealthPlan secure member portal at www.sanfordhealthplan.com/memberlogin.

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

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

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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

Special Communication & Language Access Services

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

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

- Hearing-impaired Members wishing to contact the Plan may call toll-free at TTY: 711. This number will connect Members to all staff/departments within the Plan (For example, Customer Service, Utilization Management, or Case Management).
- Visually impaired Members may contact our Customer Service Department toll-free at (855) 305-5060 | TTY: 711 to request large-print or audio versions of the Plan's documents and Member materials.
- For Members who have trouble reading Plan documents, or understanding written Member materials, Plan representatives can read information to Members over the phone.

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

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

Medical Terminology

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

Definitions

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

Value-Added Program

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

Conformity with State and Federal Laws

Any provision in this Certificate of Coverage not in conformity with North Dakota Century Code chapters 26.1-18.1 and 26-1-36, North Dakota Administrative Code chapter 45-06-07, or any other applicable law or rule in this state, or at the federal level, may not be rendered invalid; but instead must be construed and applied as if it were in full compliance with any applicable North Dakota and Federal law and/or rule.

Service Area

North Dakota

| | | | | |
|-----------|---------------|-----------|----------|----------|
| Adams | Divide | Lamoure | Pembina | Stark |
| Barnes | Dunn | Logan | Pierce | Steele |
| Benson | Eddy | McHenry | Ramsey | Stutsman |
| Billings | Emmons | McIntosh | Ransom | Towner |
| Bottineau | Foster | McKenzie | Renville | Triall |
| Bowman | Golden Valley | McLean | Richland | Walsh |
| Burke | Grand Forks | Mercer | Rolette | Ward |
| Burleigh | Grant | Morton | Sargent | Wells |
| Cass | Griggs | Mountrail | Sheridan | Williams |
| Cavalier | Hettinger | Nelson | Sioux | |
| Dickey | Kidder | Oliver | Slope | |

Minnesota

| | | |
|----------|--------|----------|
| Kittson | Norman | Traverse |
| Marshall | Clay | Marshall |
| Polk | Wilkin | Roberts |

South Dakota

| | | |
|---------|----------|-----------|
| Harding | Corson | McPherson |
| Perkins | Campbell | Brown |

Montana

| | | |
|-----------|----------|--------|
| Sheridan | Richland | Fallon |
| Roosevelt | Wibaux | Carter |

Section 1. Enrollment

How and When Coverage Begins

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

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

DEPENDENTS

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

Eligibility Requirements

To be eligible to enroll in this plan, you:

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

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

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

NOTE: In order to ensure timely delivery of any notification from the ND DHS Medical Services Division, and to prevent possible disenrollment due to failure to respond, **report any address changes to your local Human Service Zone office as soon as you know you will be moving, or have a change in mail delivery.**

Excluded Populations

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

ND TRADITIONAL MEDICAID OR OTHER STATE'S MEDICAID EXCLUSION. This Certificate of Coverage does not cover any individual who is enrolled in ND Traditional Medicaid or any other state's Medicaid. To be eligible for coverage, a Member cannot also have coverage under any other Medicaid program. If it is determined that a Member also had coverage under any other Medicaid program at the time of eligibility under Medicaid Expansion, coverage under Medicaid Expansion shall cease and may be retroactively terminated to the date of any other Medicaid program eligibility occurred, as determined by the North Dakota Department of Human Services Division of Medical Services.

NEWBORN AND DEPENDENT EXCLUSION. This Certificate of Coverage does not cover newborns and/or Dependents. A newborn infant may be eligible to be covered by the North Dakota Medicaid or the Children's Health Insurance Program from birth. Contact your local Human Service Zone office or the North Dakota Department of Human Services Division of Medical Services for questions regarding eligibility.

Coverage Changes

As a condition of Medicaid eligibility, you must report any change in circumstance(s) which may impact your eligibility and/or coverage.

Within ten (10) days of the date of an event that may change your eligibility for coverage: You must tell your local Human Service Zone office or the ND DHS Medical Service Division by calling (701) 328-2321 | (844) 854-4825 (toll-free) | TTY: 711.

Failure to timely report a change in circumstance(s) may be grounds for review by your local Human Service Zone office or the ND DHS Division of Medical Services. Upon review, if determined that the change in circumstance(s) would have resulted in a loss of eligibility had it been reported timely, you will be responsible for reimbursing the provider(s) for any health care service(s) you may have received during the identified timeframe.

The following events may require a change in your coverage, as determined by the North Dakota Department of Human Services Division of Medical Services:

1. Active Duty in the military;
 2. Eligibility or enrollment in Medicare;
 3. Enrollment in this State's or any other state's Traditional Medicaid program;
 4. Death;
 5. Pregnancy;
 6. Change in the number of people living in your household;
 7. Incarceration or release from incarceration;
 8. Change in citizenship status or Native Alaskan/Native American Tribal affiliation;
 9. A change in employment status;
 10. A change in income including any increase or decrease with salary, tips, and/or shifts; or
 11. A change in legal residency or a move outside of the state of North Dakota, as determined by the North Dakota Department of Human Services.
-

Section 2. How Coverage Ends

Termination of Coverage

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

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

- a. The Member ceases to be a legal resident of North Dakota or moves outside of the state of North Dakota as determined by the North Dakota Department of Human Services Division of Medical Services.
- b. The Member ceases to be eligible for the Medicaid Expansion Program as determined by the North Dakota Department of Human Services Division of Medical Services.
- c. The Member dies.

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

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

- a. The Member makes material misrepresentations or commits fraud; or
- b. The Member misuses or commits fraud in the use of his or her Plan ID card; or
- c. The Member's conduct is abusive or obstructive to Sanford Health Plan's personnel, Network Providers or other Members; or
- d. The Member repeatedly and intentionally misuses Sanford Health Plan's benefits and services; or
- e. The Member fails to cooperate in coordinating benefits or subrogating the Member's right of recovery; or
- f. Death of a Member; or
- g. Confinement of a Member in an institution when such confinement is a non-covered service under this Certificate of Coverage.

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

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

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

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

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

- a. At least *ten (10) calendar days* prior to the date of termination, suspension, or reduction in covered services; or
- b. If the Plan has facts indicating that the action should be taken because of probable fraud by the Member and the facts have been verified, if possible, through secondary sources, *five (5) calendar days* before date of the termination, suspension, or reduction in covered services; or
- c. By the date of the termination, suspension, or reduction in covered services if:
 1. the Plan has factual information confirming the death of the Member;
 2. the Plan receives a clear, written statement from the Member that:
 - i. The Member no longer wants the services; or
 - ii. The Member gives information that requires termination or reduction of services and indicates that he or she understands that this shall be the result of supplying that information;
 3. The Member has been admitted to an institution where he or she is ineligible for further services;
 4. The Member's whereabouts are unknown and the post office returns mail directed to the Member indicating no forwarding address. In this case, any discontinued services shall be reinstated if the Member's whereabouts become known during the time the Member remains eligible for services;
 5. The Member has been accepted for Medicaid services by another local jurisdiction; or
 6. The Member's physician prescribes the change in the level of medical care.

The above actions are subject to review and approval by the North Dakota Department of Human Services Division of Medical Services.

Questions about the disenrollment process should be directed to:

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

Retroactive Eligibility and Terminations

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

Section 3. How You Get Care

Identification cards

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

If you need replacement cards, call us toll-free at (855) 305-5060 | TTY: 711 or write to us at PO Box 91110 Sioux Falls, SD 57109-1110. You may also request replacement cards through our website at www.sanfordhealthplan.com.

Conditions for Coverage

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

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

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

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

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

In addition, all Health Care Services are subject to:

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

Network Coverage

Network coverage applies when Covered Services are received from the following:

- (1) Network Providers;
- (2) Out-of-Network Providers who provide emergency or urgent care;
- (3) Out-of-Network Providers who provide family planning care; or
- (4) Out-of-Network Providers when access to a Network Provider is not available or feasible, and authorization is obtained from Sanford Health Plan.

A Provider is considered a Network Provider if contracted with Sanford Health Plan for the North Dakota Medicaid Expansion Network, enrolled with state of North Dakota Medicaid Program, and located within the Service Area. The following facilities and/or providers within the Service Area are considered Network Providers regardless of contracting status with Sanford Health Plan: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Care Providers (IHCP). If the requirements to be a Network Provider are not met, then a Provider is considered an Out-of-Network Provider.

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

This Certificate of Coverage DOES NOT include Out-of-Network Coverage.

Covered Services received Out-of-Network must meet the criteria for Network Coverage.

If you choose to receive Covered Services from an Out-of-Network Provider without a reason for Network Coverage, you will be responsible for all financial charges from that Provider.

Appropriate Access

Primary Care Physicians, Specialty Providers and Hospital Providers

1. Appropriate access for Primary Care Practitioners, Specialty Providers, and Hospital Provider sites is defined as the Plan ensuring that Network Providers are available within *fifty (50)* miles of a Member's legal North Dakota residence.
2. Appropriate access includes access to Network Providers when the Member has traveled outside of the Service Area and has either obtained prior approval by the Plan, or is experiencing an Emergency Medical Condition or Urgent Care Situation.
3. Members who are inside the Plan's Service Area must use the Plan's Network of Network Providers. If you are traveling within the Service Area where Network Providers are available then you must use Network Providers.
4. If a Member chooses to go to an Out-of-Network Provider when access is available from a Network Provider, the Member will be

responsible for all financial charges from that Provider.

5. All services must be rendered within the United States.

Transplant Services

Transplant Services must be performed at designated Plan Network *Centers of Excellence*, or Plan-approved facilities, and is not subject to Appropriate Access standards, as outlined above. Transplant coverage includes related post-surgical treatment, drugs, eligible travel, and living expenses and shall be subject to and in accordance with the provisions, limitations, and terms of the Plan's transplant policy.

Coverage Determination Review Process

Coverage Determinations - OVERVIEW

The Appeals and Denials Department will coordinate the Covered Service Determination, Non-Covered Service Determination, and Appeal process. Appeals and Denials will review the request using standards established by the Plan and, if the request is approved, provide notification of the determination, or if the request is denied, provide notification of the determination and relevant Appeal rights. A coverage determination will be made *within fourteen (14) calendar days* of receipt of the request. If the Plan is unable to make a decision due to matters beyond its control, it may extend the decision timeframe once, for up to *fourteen (14) calendar days*.

Within *fourteen (14) calendar days* of receiving a service request, Sanford Health Plan will notify the Member or Member's Authorized Representative if an extension is needed and the date by which it expects to make a decision. The Plan will issue and carry out its determination as expeditiously as the Member's medical condition requires and no later than the date on which the extension expires.

For coverage determinations, Appeals and Denials reviews Certificate of Coverage language, contractual terms, and administrative policies related to services covered under this Plan, and requests for coverage of services that do not involve medical necessity. All coverage determinations that are Adverse will be made by the person assigned to coordinate Benefit, Denial, and Appeal processes.

The Appeals and Denials Department is available between the business hours of 8 a.m. and 5 p.m. Central Time, Monday through Friday, by calling Sanford Health Plan's toll-free number (877) 652-8544 | TTY: 711. After these business hours, you may leave a confidential voicemail and someone will return your call on the next business day. You may also fax Sanford Health Plan at (605) 312-8910.

The date of receipt for non-urgent (standard) requests received outside of normal business hours will be the next business day.

Routine (Non-Urgent) Pre-Service Coverage Determinations

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

Lack of Necessary Information

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

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

Timeframe Extensions

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

Non-Covered Service Determinations

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

Post Service Coverage (Standard/Non-Urgent) Review Process

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

Sanford Health Plan will review the request and make the decision to approve or deny within *thirty (30) calendar days* of receipt of

the request. Written or electronic notification will be made to the Member within those *thirty (30) calendar days*. Members will be notified by the Plan upon receipt of the Appeal and upon the Plan's decision on the Appeal.

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

Utilization Review Process

The Plan's Utilization Management Department is available between the business hours of 8:00 am to 5:00 pm Central Time, Monday through Friday, by calling the Plan's toll-free number (855) 276-7214 | TTY: 711. After business hours, you may leave a confidential voicemail for the Utilization Management Department and someone will return your call on the next business day. You may also fax the Plan at (605) 328-6813.

The date of receipt for non-Urgent Requests received outside of normal business hours will be the next business day. The date of receipt for Urgent Requests will be the actual date of receipt, whether or not it is during normal business hours.

All Utilization Management Adverse Benefit Determinations will be made by the Sanford Health Plan Chief Medical Officer, designee, or appropriate Practitioner.

Authorization (Certification)

Authorization (certification) is approval of a requested service for medical care, including care for behavioral, mental health, and/or substance use disorders, prior to receiving the service. Authorization (Certification) is designed to facilitate early identification of the treatment plan to ensure medical management and available resources are provided throughout an episode of care.

The Plan determines approval for authorization (Certification) based on appropriateness of care and service and existence of coverage. The Plan does not compensate Practitioners/Providers or other individuals conducting utilization review for issuing denials of coverage or service care. Any financial incentives offered to Utilization Management decision makers do not encourage decisions that result in underutilization and do not encourage denials of coverage or service.

The Member is ultimately responsible for obtaining authorization (Certification) from the Utilization Management Department in order to receive Network coverage. However, information obtained by the provider/practitioner's office may also satisfy this requirement. Primary care physicians and any Network Specialists have been given instructions on how to get the necessary authorizations (Certifications) for surgical procedures or hospitalizations you may need.

Members are responsible to confirm with the Practitioner/Provider that any required authorization (Certification) has been obtained from the Plan prior to receiving services.

See "*Services that Require Authorization (Certification)*" on the following pages.

Services that Require Authorization (Certification)

| Service | See Section: |
|---|-------------------------|
| Admissions Inpatient (medical, surgical, mental health/substance abuse), inpatient rehabilitation, long-term acute care, residential treatment, skill nursing facility, swing bed facility, and rehabilitation center admissions. NOTE: Admission before the day of non-emergency surgery will not be approved unless the early admission is determined to be Medically Necessary by the Plan. Coverage for hospital expenses prior to the day of surgery will be denied unless authorized prior to being incurred. | 4(a), 4(b), 4(d) |
| Ambulance Services (Non-Emergent Air or Ground) | 4(c) |
| All Clinical Trials | 4(a) |
| Durable Medical Equipment (DME) Includes but not limited to: Airway clearance device, communication device, cranial molding helmet, equipment over \$10,000, hospital or specialty beds, insulin pumps, selected orthotics, phototherapy UVB light devices, pneumatic compression device (external pump), power wheelchairs or scooters, prosthetic limbs. | 4(a) |
| Home Health and Home IV Therapy Services | 4(a), 4(b) |
| Implants and Stimulators External bone growth stimulator, cochlear implant (device and procedure), deep brain stimulator, gastric stimulator, spinal cord stimulator (device and procedure), Vagus nerve stimulator, and device insertion, revision, removal and trials. | 4(a) |

| | |
|--|-------------------------|
| Oncology Services and Treatment All chemotherapy and radiation therapy as part of an oncology treatment plan. | 4(a) |
| Select Outpatient Services and Treatments Includes but is not limited to: Applied Behavior Analysis (ABA), alopecia treatment, non-cosmetic botox, brachytherapy, chelation therapy, dental anesthesia, genetic testing, home sleep study, hyperbaric oxygen therapy, medical nutrition, neuromuscular electrical estimation, medically necessary orthodontia, photodynamic therapy, platelet rich plasma (PRP), radiofrequency ablation, varicose vein treatment. | 4(a), 4(b) |
| Outpatient Surgery Includes but not limited to: Abdominoplasty or Panniculectomy, bariatric surgery, blepharoplasty, breast implant removal, revision or re-implantation, breast reconstruction, mastectomy, endoscopic sinus surgery, intrathecal pain pump, mammoplasty, Orthognathic procedures, rhinoplasty, septoplasty, back surgery, temporomandibular joint (TMJ) | 4(a), 4(b), 4(f) |
| Transplant Services Includes transplant evaluation and all transplants services including artificial pancreas | 4(b) |
| Services by Out-of-Network Providers Authorization (Certification) is required for the purposes of receiving Network coverage for health care services by an Out-of-Network Provider. | 4(g) |

Prescription Drugs – Outpatient Retail Pharmacy Services

Outpatient retail pharmacy benefits are administered by the North Dakota Department of Human Services (DHS), and NOT by Sanford Health Plan. Certain medications in the State of North Dakota’s Medicaid Preferred Drug List (PDL) require authorization. If you have questions about your pharmacy benefit, please call ND DHS at please call ND DHS at 1-800-755-2604 | TTY: 711

Routine (Non-Urgent) Pre-Service Review Process for Elective Inpatient Hospitalizations or Non-Urgent Medical Care Requests

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

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

- a. Member medical information including:
 - i. diagnosis
 - ii. medical history
 - iii. presence of complications and/or co-morbidities;
- b. Consultation with the treating Physician, as appropriate;
- c. Availability of resources and alternate modes of treatment; and
- d. For admissions to facilities other than acute Hospitals additional information may include but are not limited to the following:
 - i. history of present illness
 - ii. Member treatment plan and goals
 - iii. prognosis
 - iv. staff qualifications
 - v. *twenty-four (24)* hour availability of qualified medical staff.

You are ultimately responsible for obtaining authorization (Certification) from the Utilization Management Department. Failure to obtain authorization (Certification) will result in the denial of payment on your claim. However, information provided by the Physician’s office to the Plan may also satisfy the requirement of a Member to get authorization (Certification). You are responsible to confirm with the Practitioner/Provider that any required Plan authorization (Certification) has been obtained prior to receiving the service.

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

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

Lack of Necessary Information

If the Plan is unable to make a decision due to lack of necessary information, it will notify the Member or the Member’s Authorized

Representative of what specific information is necessary to make the decision *within fourteen (14) calendar days* of the Routine Pre-Service Review request.

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

Timeframe Extensions

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

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

NOTE: If the information is not received by the end of the *forty-five (45) calendar day* extension, Sanford Health Plan will deny the request. If the Plan receives a request that fails to meet the procedures for Routine Pre-Service Review Request, the Plan will notify the Practitioner/Provider or Member of the failure and proper procedures to be followed as soon as possible but no later than *five (5) calendar days* after the date of the failure. The Plan will give oral and/or written notification to the Member, Practitioner and those Providers involved in the provision of the service.

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

Adverse Benefit Determinations

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

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

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

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

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

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

In determining whether a request is "Urgent," the Plan shall apply the judgment of a prudent layperson that possesses an average knowledge of health and medicine. When a Practitioner with knowledge of the Member's medical condition determines the condition to be an *Urgent Care Situation*, the Plan shall treat the routine pre-service review as an Urgent Care Request.

For Urgent Medical Care Requests: the determination for medical care, including care for behavioral, mental health, and/or substance use disorders will be made by the Utilization Management Department as soon as possible (taking into account medical emergencies, but no later than *seventy-two (72) hours* after receipt of the request. Notification of the determination will be made to the Member or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service, via oral communication by the Utilization Management Department as soon as possible but no later than *seventy-two (72) hours* of receipt of the request. For authorizations (Certifications) and Adverse Benefit Determinations, the Plan will give electronic or written notification of the decision to the Member, Practitioner and those Providers involved in the provision of the service as soon as possible but no later than *seventy-two (72) hours* of the oral notification.

Routine Pre-Service Review for Urgent/Emergency Medical Care Request is not required for Emergency Medical Conditions.

However, the Plan must be notified by the Member as soon as reasonably possible but no later than *ten (10) days* after the Member is physically or mentally able to do so. A Member's Authorized Representative may notify the Plan on the Member's behalf with written permission of the Member.

Lack of Necessary Information

If the Plan is unable to make a decision due to lack of necessary information, it may extend the decision timeframe once for up to *forty-eight*

(48) hours to request additional information. An extension is permitted if the Member, Member's Authorized Representative, and/or Practitioner/Provider requests it or the Plan justifies to the State, upon request, that additional information is needed and that the extension is in the Member's interest.

Timeframe Extensions

Within *twenty-four (24) hours* after receipt of the Urgent/Emergency Medical Care and/or Pharmaceutical Request, the Plan will notify the Member, or the Member's Authorized Representative, of what specific information is necessary to make the decision. In addition to notifying the Member, the Plan will notify the Practitioner of the information needed if the request for health care services came from the Practitioner. Sanford Health Plan will give the Member or the Member's Authorized Representative a reasonable amount of time taking into account the circumstances, but not less than *forty-eight (48) hours* to provide the specified information.

If the Plan receives a request that fails to meet the procedures for Urgent/Emergency Medical Care and/or Pharmaceutical Requests, the Plan will notify the Practitioner and Member of the failure and proper procedures to be followed as soon as possible but no later than *twenty-four (24) hours* after the date of the failure. The Plan will give oral and/or written notification to the Member, Practitioner and those Providers involved in the provision of the service.

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

Adverse Benefit Determinations

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

Concurrent Review Process for Medical Care Requests

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

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

Requesting Authorized Services be Extended

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

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

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

Any reduction or termination by the Plan during the course of treatment before the end of the period or number treatments shall constitute an Adverse Benefit Determination.

Urgent Concurrent Reviews Requested At Least Twenty-Four (24) Hours in Advance of an Expiring Authorization (Certification)

For requests to extend the course of treatment beyond the initial period of time or the number of treatments, if the request is made at least *twenty-four (24) hours* prior to the expiration of the prescribed period of time or number of treatments, the Plan shall conduct an Urgent Concurrent Review and orally notify the Member, or the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service of the determination as soon as possible taking into account the Member's medical condition but in no event more than *twenty-four (24) hours* after the date of the Plan's receipt of the request. The Plan will provide electronic or written notification of an authorization (Certification) to the Member, the Member's Authorized Representative, Practitioner and those Providers involved in the provision of the service within *seventy-two (72) hours* after the oral notification.

Adverse Benefit Determinations

The Plan shall provide written or electronic notification of the Adverse Benefit Determination to the Member, or the Member's Authorized Representative, and those Providers involved in the provision of the service sufficiently in advance (but no later than *seventy-two (72) hours* of the telephone (oral) notification) of the reduction or termination to allow the Member or, the Member's Authorized Representative to file

an Appeal request of the Adverse Benefit Determination and obtain a determination with respect to that review before the benefit is reduced or terminated. The Plan will terminate payment of benefits on the date that oral notification of the reduction or termination of benefits is made.

Urgent Concurrent Reviews Requested *Within Twenty-Four (24) Hours of an Expiring Authorization (Certification)*

If the request to extend Urgent Concurrent Review is not made at least *twenty-four (24) hours* prior to the expiration of the prescribed period of time or number of treatments for medical care, including care for behavioral, mental health, and/or substance use disorders, Sanford Health Plan will treat it as an Urgent (Pre-Service) Medical Care Request and make the decision as soon as possible (taking into account the medical exigencies) but no later than *twenty-four (24) hours* after the request.

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

Adverse Benefit Determinations

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

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

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

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

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

Lack of Necessary Information

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

Timeframe Extensions

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

Adverse Benefit Determinations

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

Written Notification Process for Non-Covered Service and Adverse Benefit Determinations

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

1. The specific reason for the Adverse Benefit Determination in easily understandable language;
2. Reference to the specific internal plan rule, provision, guideline, or protocol on which the determination was based and notification that the Member will be provided a copy of the actual plan provisions, guidelines, and protocols free of charge upon request. Reasons for any denial of reimbursement or payment for services with respect to benefits under the Plan will be provided within *thirty (30) calendar days* of a request;
3. If the Adverse Benefit Determination is regarding coverage for a mental health and/or substance use disorder, a statement notifying Members of their opportunity to request treatment and diagnosis code information free of charge. Any request for diagnosis and treatment code information may not be (and is not) considered a request for an internal Appeal or External Review;
4. If the Adverse Benefit Determination is based in whole or in part upon the Member failing to submit necessary information, the notice

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- shall include a description of any additional material or information which the Member failed to provide to support the request, including an explanation of why the material is necessary;
5. If the Adverse Benefit Determination is based on medical necessity or an Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the Plan to the Member's medical circumstances, or a statement that an explanation will be provided to the Member free of charge upon request;
 6. For Mental Health and/or Substance Use Disorder (MH/SUD) Adverse Benefit Determinations, if information on any medical necessity criteria is requested, documents will be provided for both MH/SUD and medical/surgical benefits within *thirty (30) calendar days* of a Member/Member's Authorized Representative/Provider's request. This information will include documentation of processes, strategies, evidentiary standards and other factors used by the plan, in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
 7. If the Adverse Benefit Determination is based on medical necessity, a written statement of clinical rationale, including clinical review criteria used to make the decision if applicable. If the denial is due to a lack of clinical information, a reference to the clinical criteria that have not been met will be included in the letter. If there is insufficient clinical information to reference a specific clinical practice guideline or policy, the letter will state the inability to reference the specific criteria and will describe the information needed to render a decision;
 8. Notification and instructions on how the Practitioner/Provider can contact the Physician and/or other appropriate Practitioners to discuss the determination;
 9. A written statement of clinical rationale, including clinical review criteria used to make the decision if applicable;
 10. A description of the Plan's Appeal procedures including how to obtain an expedited review if necessary (and any time limits applicable to those procedures), the right to submit written comments, documents or other information relevant to the Appeal; an explanation of the Appeal process including the right to Member representation; how to obtain an Expedited review if necessary and any time limits applicable to those procedures; notification that Expedited External Review can occur concurrently with the internal Appeal process for Urgent care/ongoing treatment; and the timeframe the Member has to make an Appeal and the amount of time the Plan has to decide it (including the different timeframes for Expedited Appeals);
 11. If the Adverse Benefit Determination is based on medical necessity, notification and instructions on how the Practitioner/Provider can contact the Physician or appropriate Practitioner to discuss the determination.
 12. For decisions not wholly in the Member's favor, the Member has the right to request a State Fair Hearing; the written decision for the External Appeal review will contain the following information:
 - a. Instructions to request a State Fair Hearing within *one hundred and twenty (120) calendar days* from the date of the written Adverse Benefit Determination notice with the following conditions:
 - i. The Member has completed the Internal Appeal process through Sanford Health Plan with the Adverse Benefit Determination being upheld, or
 - ii. Sanford Health Plan has failed to adhere to the notice and timing requirements of the Internal Appeal process which then the Member is deemed to have exhausted the Plan's appeal process;
 - b. How the Member or their representative may request a State Fair Hearing;
 - c. Parties to the State Fair Hearing are a Member, health care Practitioner/Provider with knowledge of the Member's medical condition, Authorized Representative of the Member, legal representative of a deceased Member's estate, and/or an attorney
 - d. The right to continue to receive benefits pending a hearing with the following conditions:
 - i. The Appeal is filed in a timely manner,
 - ii. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment,
 - iii. The services were ordered by an authorized Provider,
 - iv. The period covered by the original authorization has not expired, and
 - v. The Member requests the extension of benefits;
 - e. How to request the continuation of benefits while an Appeal is pending; and
 - f. A statement saying if the Plan's action is upheld in a hearing, the Member may be liable for the cost of the cost of services furnished while the Appeal was pending.
 - g. If the Plan or the State Fair Hearing Officer reverses a decision to deny, limit, or delay services that were not furnished while the appeal was pending, then the Plan will authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires. If overturned by the State Fair Hearing, SHP will authorize or provide the disputed services promptly but no later than 72 hours from the date we receive notice reversing the determination.
 - h. Requests for a State Fair Hearing can be made to:

Appeals Supervisor, Legal Advisory Unit
N.D. Department of Human Services
600 E Boulevard Avenue, Dept. 325
Bismarck, ND 58505-0250
Phone: (701) 328-2311
Toll-Free: (800) 472-2622
ND Relay TTY: (800) 366-6888 (*toll-free*)
Email: dhslau@nd.gov
 - i. Non-Covered Service Determinations are not eligible for State Fair Hearing requests.

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Section 4(a) Medical services and supplies provided by health care professionals

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

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

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Benefit Description

Diagnostic and treatment services benefit

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

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

1. Second opinions are covered at no cost to the Member from a qualified Network health care professional, and/or the arrangement for the Member to obtain one Out-of-Network if a there is not a doctor available Network.
2. Second opinions by an Out-of-Network Provider must be Authorized by the Plan prior to receiving services.

Lab, x-ray and other diagnostic tests benefit

Coverage includes:

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

Not Covered: *Thermograms or thermography*

Telehealth, e-visit, and video visits benefit

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

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

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

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

NOTE: Charges for telehealth, e-visit, and video visit services may be subject to deductible/coinsurance; see your SBC for details. Cost sharing for these services does not include any related pharmacy charges.

Not Covered:

- *Transmission fees*
- *Services for excluded benefits*
- *Services not medically appropriate or necessary*
- *Installation or maintenance of any telecommunication devices or systems*
- *Provider-initiated e-mail*
- *Appointment scheduling*

- *A service that would similarly not be charged for in a regular office visit*
- *Reminders of scheduled office visits*
- *Requests for a referral*
- *Consultative message exchanges with an individual who is seen in the Provider's office following a video visit for the same condition, per Plan guidelines*
- *Clarification of simple instructions*
- *Telephone assessment and management services*

Preventive care benefit

Preventive Care coverage is as follows:

As outlined in the Plan Preventive Health Guidelines, the following preventive services under the Affordable Care Act (ACA) received from a Network Provider are covered without any copayment requirement that would otherwise apply:

1. Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF). These services are preventive, as required under the ACA, and include, but are not limited to:
 - a. Colonoscopies;
 - b. Prostate screening;
 - c. Mammograms;
 - d. Total blood cholesterol; and
 - e. Genetic Testing. *This requires authorization (Certification).*
2. Immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Member involved;
NOTE: Immunizations for Foreign Travel are not covered as preventive services.
3. With respect to covered persons who are age 19 or 20, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and
4. With respect to covered persons who are women, such additional preventive care and screenings not described above as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. You do not need prior authorization from the Plan or any other person in order to obtain access to obstetrical and/or gynecological care through a Network Provider. To view the Plan's *Preventive Health Guidelines*, visit www.sanfordhealthplan.com.

Not Covered:

- *Sports physicals, pre-employment and employment physicals, insurance physicals, or government licensing physicals (including, but not limited to, physicals and eye exams for driver's licenses)*
- *Virtual colonoscopies.*

Tobacco cessation treatment benefit

Tobacco cessation treatment coverage is as follows:

As defined in the Affordable Care Act, Evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force when received from a Network Provider are covered without payment requirements that would otherwise apply. Tobacco-cessation treatment includes:

- Screening for tobacco use; and
- At least two (2) tobacco-cessation attempts per year (for Members who use tobacco products). Cessation attempt is defined to include coverage for:
 - Four (4) tobacco-cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization
 - All Food and Drug Administration (FDA)-approved tobacco-cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care Provider without prior authorization. (Refer to Section 4(e) Outpatient prescription drug benefits for additional information)

Not Covered: *Hypnotism and Acupuncture*

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

Early Periodic Screening, Diagnosis, and Treatment coverage is as follows:

Coverage is provided for preventive, routine, and necessary medical care to correct or ameliorate a condition for Members age 19 or 20 under the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit. Federal regulations require ND Medicaid Expansion Members ages 19 or 20 to be informed of the ND Health Tracks Program which offers comprehensive screening by a medical professional with referrals made to doctors, dentists, and/or other specialist for diagnosis/treatment if any problems or concerns are identified. To schedule an appointment for a Health Tracks Screening, contact your local Human Service Zone office.

- EPSDT benefits include the following diagnostic and treatment services:
 - a. Screening Services include periodic wellness examinations that include physical and mental health assessments.
 - b. Vision services include screening, diagnosis, and treatment for defects in vision. See *Vision services (testing, treatment, and*

supplies) later in this Section for details.

- c. Dental services include screening, relief of pain and infections, restoration of teeth and maintenance of dental health. Coverage includes regular preventive dental care and treatment. See Section 4(f) *Dental benefits* for details.
 - d. Hearing services include screening, diagnosis and treatment for defects in hearing, including the provision of hearing aids or implants if medically necessary (*authorization (Certification) required*).
 - e. When a Practitioner or Provider shows that a Member ages 19 or 20 might have a health problem, related diagnostic testing and evaluations will be provided under EPSDT at no cost. Also included are any necessary referrals so that the Member receives all medically necessary treatment.
- Benefits provided under EPSDT terminate at the end of the month in which the Member reaches age *twenty-one (21)*.
 - For information specific to mental health and substance use disorder treatment under EPSDT, see Section 4(d).

Maternity care benefit

Maternity coverage is as follows:

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

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

Covered maternity screenings include:

- Screening for gestational diabetes mellitus during pregnancy
 - Testing includes a screening blood sugar followed by a glucose tolerance test if the sugar is high.
- Prenatal vitamins (Refer to Section 4(e) Outpatient Prescription Drug Benefits for additional information)
- Anemia screening
- Bacteruria (bacteria in urine) screening
- Hepatitis B screening
- Rh (Rhesus) incompatibility screening: first pregnancy visit and 24-28 weeks gestation
- Genetic counseling or testing. *Authorization (Certification) is required.*
- Preeclampsia prevention
- Maternal Depression Screening after delivery for mothers who are ages 19 and 20

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

Maternity care includes prenatal through postnatal maternity care and delivery, and care for complication of pregnancy of mother. We cover up to four (4) routine ultrasounds per pregnancy to determine fetal age, size, and development, per Plan guidelines.

The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of *forty-eight (48) hours* for a vaginal delivery to a minimum of *ninety-six (96) hours* for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Practitioner/Provider, after consulting with the Member, determines that the Member meets certain criteria and that such discharge after delivery is medically appropriate. If the inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the Member by Network Practitioners/Providers competent in postpartum care.

NOTE: We encourage you to participate in our Healthy Pregnancy Program; Call (888) 315-0884 (*toll-free*) or TTY: 711 to enroll.

Not Covered:

- *Amniocentesis or chorionic villi sampling (CVS) solely for sex determination*
- *Bottles, breast milk storage bags and supplies related to bottles*
- *Breastfeeding pumps and supplies obtained from drugstores or department stores*
- *Home birth settings, related equipment and fees*
- *Non-licensed birthing assistance, such as doulas*
- *Maternity classes and/or education programs*
- *Elective abortion services, except in cases of rape, incest, or when the mother's life is endangered. Authorization (Certification) required.*

Newborn exclusion

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

Family planning and contraceptive services benefit

NOTE: Family planning benefits are available from Network and Out-of-Network Providers without Authorization (Certification).

Family planning coverage is as follows:

- Consultations and pre-pregnancy planning.
- Member education and counseling, as prescribed by a health care provider for women with reproductive capacity.
- Voluntary Sterilizations, including tubal ligations and vasectomies.
- Folic acid supplements are covered at 100% (no cost) for women planning to become pregnant or in their childbearing years.
- Sanford Health Plan covers, without cost-sharing, *at least one form* of contraception in each of the eighteen (18) methods below that the FDA has identified for women in its current Birth Control Guide. These methods fall into three (3) categories.
 - a. Obtained during an office visit/medical procedure:
 - i. Surgical sterilization implant/occlusion of the fallopian tubes by use of permanent implants
 - ii. Sterilization surgery/tubal ligation covered at 100% only when performed as the primary procedure
 - iii. Implantable devices (Placement and removal is covered per device guidelines or as Medically Necessary). Includes
 - Implantable rod.
 - IUD Copper
 - IUD Progestin
 - iv. Shot/Injection: includes injectable medroxyprogesterone acetate
 - v. Cervical Cap.
- A one-time twelve (12) month prescription dispensing of contraceptives is covered when received from a Family Planning Clinic. After the one time fill, further prescriptions must be received from a pharmacy enrolled with North Dakota Medicaid (Refer to Section 4(e) Outpatient Prescription Drug Benefits for additional information).

Not Covered:

- *Reproductive Health Care Services prohibited by the laws of this State*
- *Elective abortion services, except in cases of rape, incest, or when mother's life is endangered. Authorization (Certification) required.*
- *Reversal of voluntary sterilization*

Infertility services benefit

Infertility benefits coverage is as follows:

Coverage is provided for testing for the diagnosis of infertility*. Testing includes, but is not limited to:

- Transvaginal ultrasound for structural evaluation (limit of 1 per calendar year)
- Sonogram (limit of 1 per calendar year)
- Screenings for stimulations of ovarian reserves and ovarian functions (limit of 1 per screening per calendar year)
- Screenings for assessment of polycystic ovarian syndrome (PCOS) (limit of 1 per calendar year)
- Semen Analysis (limit of 2 per calendar year)

*Coverage is subject to Sanford Health Plan Guidelines.

Not Covered:

- *Treatment of infertility, including artificial means of conception such as:*
 - *Artificial insemination, in-vitro fertilization, ovum or embryo placement or transfer, or gamete intra-fallopian tube transfer.*
- *Cryogenic or other preservation techniques used in such or similar procedures;*
- *Infertility medication;*
- *Any other services or supplies related to artificial means of conception;*
- *Reversals of prior sterilization procedures; and/or*
- *Any expenses related to surrogate parenting or surrogate pregnancies*

Allergy care benefit

Allergy care coverage is as follows:

- Testing and treatment
- Allergy injections
- Allergy serum

Not Covered:

- *Provocative food testing*
- *Sublingual allergy desensitization*
- *Air conditioners, air filters, or other products to eradicate dust mites*
- *Any form of allergy testing and immunotherapy that is considered experimental or not FDA approved*
- *Chiropractic manipulations for allergies*
- *Diet therapy (specialty foods) for allergies*

-
- Duplicate services, including allergy testing for percutaneous scratch tests, intradermal tests, and patch tests
 - Homeopathic treatment of allergies
-

Amino acid-based elemental oral formulas benefit

Amino acid-based elemental oral formula coverage is as follows:

- Coverage for medical foods and low-protein modified food products determined by a physician to be medically necessary for the therapeutic treatment of an inherited metabolic disease of amino acid or organic acid.
-

Not Covered:

- Dietary desserts and snack items
 - Low protein modified food products or medical food for PKU to the extent those benefits are available under a Department of Health program or other state agency
-

Phenylketonuria (PKU) benefit

Phenylketonuria Coverage is as follows:

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

Not Covered:

- PKU Dietary desserts and snack items
 - Low protein modified food products or medical food for PKU to the extent those benefits are available under a Department of Health program or other state agency
-

Chiropractic services benefit

Chiropractic service coverage is as follows:

- Non-Surgical Spinal treatment and chiropractic services
 - Limited to *twenty (20)* visits each Calendar Year, regardless of whether performed by a chiropractor or other licensed Provider authorized to perform such services
-

Not Covered:

- Vitamins or minerals not otherwise listed as Covered under this Certificate of Coverage;
 - Therabands
 - Cervical pillows
 - Traction services;
 - Hot/cold pack therapy, including polar ice therapy and water circulating devices
-

Dialysis benefit

Dialysis coverage is as follows:

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

Not Covered:

- Dialysis services received without Prior-certification from Out-of-Network Providers without authorization (Certification) when traveling out of the Service Area
 - Hemodialysis machine (not separately payable)
 - Wearable artificial kidney, each
 - Compact (portable) travel hemodialyzer system
 - Unspecified complication of kidney transplant
-

Diabetes supplies, equipment, and education benefit

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

Diabetic Services coverage is as follows:

| <u>Item (*Indicated DME required authorization (Certification))</u> | <u>Must be obtained at:</u> | <u>Benefit/Cost Information</u> |
|--|----------------------------------|---------------------------------|
| <ul style="list-style-type: none"> • Lancets and lancet devices • Blood Glucose test stripes • Urine testing strips • Glucometers • Glucagon • Glucose Agents • Prescribed oral agents for controlling blood sugars • Syringes | Pharmacy (prescription required) | Pharmacy Benefit |
| <ul style="list-style-type: none"> • Blood glucose monitors, including Continuous Glucose Monitors (CGM)* • Insulin infusion devices* • Insulin Pump Supplies • Continuous Glucose Monitor Supplies* • Custom diabetic shoes and inserts limited to <i>one (1) pair</i> of depth- inlay shoes and <i>three (3) pairs</i> of inserts; or <i>one (1) pair</i> of custom molded shoes (including inserts) and <i>three (3)</i> additional pairs of inserts | Durable Medical Provider | Medical Benefit |

Additional coverage includes:

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

Not Covered: Food items for medical nutrition therapy

Durable medical equipment (DME) benefit

Durable medical equipment (DME) coverage is as follows:

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

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

- | | |
|--|---|
| a. Airway Clearance Device | f. Prosthetic Limb |
| b. Beds such as Hospital beds and mattresses | g. Selected Orthotics |
| c. Communication Device | h. Pneumatic Compression with external pump |
| d. Cranial Molding Helmet | i. Phototherapy UVB Light Device |
| e. Insulin Pump | j. Equipment over \$10,000 |

Not Covered:

- Home Traction Units
- Commodes and/or similar convenience items
- Orthopedic shoes; custom made orthotics if not covered by Sanford's internal guidelines; over-the-counter orthotics and appliances
- Disposable supplies (including diapers) or non-durable supplies and appliances, including those associated with equipment determined not to be eligible for coverage
- Revision of durable medical equipment, except when made necessary by normal wear or use

- Replacement or repair of equipment if items are damaged or destroyed by Member misuse, abuse, or carelessness; or if lost or stolen
- Duplicate or similar items
- Sales tax, mailing, delivery charges, service call charges, or charges for repair estimates
- Items, which are primarily educational in nature, or for vocation, comfort, convenience or recreation
- Household equipment which primarily has customary uses other than medical, such as, but not limited to, air purifiers, central or unit air conditioners, water purifiers, non-allergic pillows, mattresses or waterbeds, physical fitness equipment, hot tubs, or whirlpools
- Household fixtures including, but not limited to, escalators or elevators, ramps, swimming pools and saunas
- Home Modifications including, but not limited to, its wiring, plumbing or changes for installation of equipment
- Vehicle modifications including, but not limited to, hand brakes, hydraulic lifts, and car carrier
- Remote control devices as optional accessories
- Upgrades of equipment for outdoor use, or equipment needed for use outside of the home that is not needed for in-home use, are not covered.
- Self-help and adaptive aids are not a covered benefit, including assistive communication devices and training aids.
- Coverage is limited to one (1) piece of same-use equipment (e.g. mobilization, suction), unless replacement is covered under the replacement guidelines in this policy. Duplicate or back up equipment is not a covered benefit.
- Deluxe equipment
- First aid or precautionary equipment such as standby portable oxygen units
- Maintenance and service fee for capped-rental items
- Any other equipment and supplies which Sanford Health Plan determines are not eligible for coverage

Implants/Stimulators benefit

Implants/Stimulators coverage is as follows:

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

NOTE: The following Implants/Stimulators require authorization (Certification); failure to get authorization (Certification) may result in a reduction or denial of benefits. See Services requiring authorization (Certification) in Section 3:

- Bone Growth (external)
- Cochlear Implant (Device and Procedure)
- Deep Brain Stimulation
- Gastric Stimulator
- Spinal Cord Stimulator (Device and Procedure)
- Vagus Nerve Stimulator
- Insertion, Removal, and Revisions of all Implants

Foot care benefit

Foot care coverage is as follows:

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

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

Not Covered:

- Cutting, removal, or treatment of corns, calluses, or nails for reasons other than authorized corrective surgery (unless otherwise listed as Covered under this Certificate of Coverage)
- Diagnosis and treatment of weak, strained, or flat feet

Home health services benefit

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

Home health services coverage is as follows:

The following is covered, if approved by the Plan in lieu of a Hospital or Skilled Nursing Facility stay:

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

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

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

Not Covered:

- *Nursing care requested by, or for the convenience of, the Member or the Member's family (rest cures)*
- *Custodial or convalescent care*

Private duty nursing benefit

NOTE: Authorization (Certification) is required; failure to get Authorization (Certification) may result in a reduction or denial of benefits if the service would not otherwise be covered. See Services requiring Authorization (Certification) in Section 3.)

Private duty nursing means nursing services for Members who require more individual and continuous care than is available from a visiting nurse. The services must be provided by a registered nurse or a licensed practical nurse in a Member's home under the direction of their physician.

Not covered:

- *Services that can be provided safely and effectively by a non-clinically trained person*
- *Services that involve payment of family members or nonprofessional care givers for services performed for the member*

Orthotic and prosthetic devices benefit

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

Orthotic and prosthetic device coverage is as follows:

- Prosthetic limbs, sockets and supplies, and prosthetic eyes
- Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Includes *two (2)* external prosthesis per Calendar Year and *four (4)* bras per Calendar Year. For double mastectomy: coverage extends to *four (4)* external prosthesis per Calendar Year and *four (4)* bras per Calendar Year.
- Adjustments and/or modification to the prosthesis required by wear/tear or due to a change in Member's condition or to improve the function are eligible for coverage and do not require prior authorization.
- Repairs necessary to make the prosthetic functional are covered and do not require authorization. The expense for repairs is not to exceed the estimated expense of purchasing another prosthesis.
- Devices permanently implanted that are not Experimental or Investigational such as artificial joints, pacemakers, and surgically implanted breast implant following mastectomy.

NOTE: Internal prosthetic devices are paid as Hospital benefits; see Section 4(b) for payment information. Insertion of the device is paid under the surgery benefit.

Not Covered:

- *Experimental and/or Investigational services or devices, unless certain criteria are met pursuant to Sanford Health Plan's medical coverage policies and approved by the Plan's Medical Officer*
- *Replacement or repair of items, if the items are damaged or destroyed by the Member's misuse, abuse or carelessness; or if lost or stolen*
- *Duplicate or similar items*
- *Service call charges, labor charges, charges for repair estimates*
- *Wigs, cranial prosthesis, or hair transplants*
- *Cleaning and polishing of prosthetic eye(s)*
- *Genital prosthetics, including penile prosthesis, and related services unless approved by the Plan's Medical Officer as a reconstructive service due to injury, illness, or a congenital defect*

Physical, cardiac, speech and occupational therapies benefit

Physical, cardiac, speech and occupational therapies coverage is as follows:

- Outpatient Rehabilitative Therapies directed at improving physical functioning of the Member, which are expected to provide significant improvement within *two (2)* months, as certified on a prospective and timely basis by the Plan.
 - Physical Therapy: limited to *thirty (30)* visits per therapy (condition) per calendar year for Members ages 21 and older.
 - Occupational Therapy: limited to *thirty (30)* visits per therapy (condition) per calendar year for Members ages 21 and older.
 - Speech Therapy: limited to *thirty (30)* visits per therapy (condition) per calendar year for Members ages 21 and older.
- Coverage is provided for habilitative services, which are health care services that help you keep, learn, or improve skills and functioning for daily living. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient and/or outpatient settings.
 - Habilitative Therapy: limited to *thirty (30)* visits per therapy (condition) per calendar year for Members ages 21 and older.
- See "Durable Medical Equipment (DME)" in this Section for coverage of devices related to rehabilitative and habilitative services.
- Services must be provided in accordance with a prescribed plan of treatment ordered by a Practitioner/Provider. Benefits are not available for Maintenance Care.
- Includes one-to-one water therapy

Not Covered:

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

Cardiac Rehabilitation Therapy

Cardiac rehabilitation therapy coverage is as follows:

- Cardiac rehabilitation delivered as part of an inpatient hospitalization
- Outpatient cardiac rehabilitation is a covered benefit when referred by a physician and provided under the general supervision of a physician (limited to 30 visits per calendar year for Members ages 21 and older)

Not covered: Maintenance Therapy

Hearing services (testing, treatment, and supplies) benefit

Hearing services coverage is as follows:

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

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

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

Additional hearing services (testing, treatment, and supplies) covered for Members ages 19 and 20

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

Not Covered:

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

Vision services (testing, treatment, and supplies) benefit

Vision Services coverage is as follows:

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

Additional vision services covered for Members ages 19 and 20

VISION EXAMS FOR MEMBERS AGES 19 AND 20

One routine vision examination is covered annually; coverage includes:

- Refraction and glaucoma screening (tonometry test);
- Dilated eye examination for diabetes-related diagnosis;

PRESCRIBED LENSES AND FRAMES FOR MEMBERS AGES 19 AND 20

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

POST-OPERATIVE REFRACTIVE EXAMINATION(S) FOR MEMBERS AGES 19 AND 20

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

Not Covered:

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

Clinical Trials benefit

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

Clinical trial benefits are as follows:

Clinical Trials are covered as Routine Patient Costs when provided as part of an Approved Clinical Trial if the services are otherwise Covered Services. A Network Practitioner and/or Provider must provide Sanford Health Plan notice of a Member's participation in an Approved Clinical Trial.

Routine Patient Costs mean the cost of Medically Necessary Health Care Services related to the care method that is under evaluation in an Approved Clinical Trial. Routine Patient Costs do not include any of the following:

- The Health Care Service that is the subject of the Approved Clinical Trial.
- Any treatment modality that is not part of the usual and customary standard of care required to administer or support the Health Care Service that is the subject of the Approved Clinical Trial.
- Any Health Care Service provided solely to satisfy data collection and analysis needs that are not used in the direct clinical management of the patient.

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- An investigational drug or device that has not been approved for market by the federal Food and Drug Administration.
 - Transportation, lodging, food, or other expenses for the patient or a family member or companion of the patient that is associated with travel to or from a Facility where an Approved Clinical Trial is conducted.
 - A Health Care Service that is provided by the sponsor of the Approved Clinical Trial free of charge for any new patient.
 - A Health Care Service that is eligible for reimbursement from a source other than this Contract, including the sponsor of the Approved Clinical Trial.
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Not covered:

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

NOTE: Authorization (Certification) is required; failure to get authorization (Certification) may result in a reduction or denial of benefits if the service would not otherwise be covered. See Services requiring authorization (Certification) in Section 3.

Oncology treatment coverage is as follows:

- Radiation Therapy.
 - Chemotherapy
 - The same cost-sharing amounts apply for intravenously administered or injected cancer chemotherapy agents as for prescribed, orally-administered, anticancer medications used to kill or slow the growth of cancerous cells
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Other medical benefit treatment therapies not specified elsewhere

Treatment therapy is as follows:

- Inhalation Therapy
 - Pheresis Therapy
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Not Covered:

- *Non-surgical treatments that do not meet the Plan's medically necessary guidelines (available upon request)*
 - *Treatment received outside of the United States*
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Section 4(b) Services provided by a Hospital or other Facility

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

- This Certificate of Coverage, including your application for coverage and any amendments, constitute your entire contract of insurance.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.
- Network Providers must provide or arrange your care and you must be hospitalized in a Network Facility.
- Mental Health and Substance Use Disorder benefits provided by a Hospital or other Facility are outlined in Section 4(d).
- Be sure to read Section 3, *How you get care*, for valuable information about conditions for coverage.
- You or your Physician must get authorization (Certification) of some services in this Section. The benefit description will say “**NOTE:** Authorization (Certification) is required for certain services. Failure to get authorization (Certification) will result in a reduction or denial of benefits (See Services requiring authorization (Certification) in Section 3.)”

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Benefit Description

Admissions benefit

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

Admission coverage for Hospital Services is as follows:

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

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

Not Covered:

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

Outpatient hospital or ambulatory surgical center benefit

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

Outpatient Hospital or Ambulatory Surgical Center Coverage is as follows:

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

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

Not Covered:

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

Skilled nursing facility services benefit

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

Skilled Nursing Facility coverage is as follows:

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

Not Covered:

- *Custodial Care*
- *Convalescent care*
- *Intermediate level or domiciliary care*
- *Residential care*
- *Rest cures*
- *Services to assist in activities of daily living*

Hospice care benefit

Hospice Care coverage is as follows:

A Member may elect to receive hospice care, instead of the traditional Covered Services provided under the Plan, when the following circumstances apply:

- a. The Member has been diagnosed with a terminal disease and a life expectancy of *six (6) months* or less;
- b. The Member has chosen a palliative treatment focus (i.e. emphasizing comfort and support services rather than treatment attempting to cure the disease or condition); and
- c. The Member continues to meet the terminally ill prognosis as reviewed by the Plan's Chief Medical Officer or designee over the course of care.

The following Hospice Services are Covered Services:

- a. 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
- b. In-home hospice care per Plan guidelines (available upon request)
- c. Part-time or intermittent nursing care by a RN, LPN/LVN, or home health aide for patient care up to *eight (8) hours* per day
- d. Social services under the direction of a Network Provider
- e. Psychological and dietary counseling
- f. Physical or occupational therapy, as described under *Section 4(a)*
- g. Consultation and Case Management services by a Network Provider
- h. Medical supplies, DME and drugs prescribed by a Network Provider
- i. Expenses for Network Providers for consultant or Case Management services, or for physical or occupational therapists, who are not group Members of the hospice, to the extent of coverage for these services as listed in *Section 4(a)*, but only where the hospice retains responsibility for the care of the Member

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

Reconstructive surgery benefit

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

Reconstructive surgery coverage is as follows:

- Surgery to restore bodily function or correct a deformity caused by illness or injury
 - Coverage for mastectomy related benefits are provided in a manner determined in consultation with the attending physician and Member. Coverage will be provided for reconstructive breast surgery and physical complications at all stages of a mastectomy, including lymphedema for those Members who had a mastectomy resultant from a disease, illness, or injury. For single mastectomy: coverage extends to the non-affected side to make it symmetrical with the affected breast post-surgical reconstruction. Breast prostheses and surgical bras and replacements are also covered (see Prosthetic devices in Section 4(a)).
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Not Covered:

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

Oral and maxillofacial surgery benefit

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

Oral and maxillofacial surgery coverage is as follows:

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

Not Covered:

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

Transplant benefit

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

Transplant services coverage is as follows:

Coverage is provided for transplants according to the Plan's medical coverage guidelines (available upon request) for the following services:

- Pre-operative care
- Transplant procedure, facility and professional fees
- Organ acquisition costs including:
 - For living donors: organ donor fees, recipient registration fees, laboratory tests (including tissue typing of recipient and donor), and hospital services that are directly related to the excision of the organ

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- For cadaver donors: operating room services, intensive care cost, preservation supplies (perfusion materials and equipment), preservation technician's services, transportation cost, and tissue typing of the cadaver organ
 - Bone marrow or stem cell acquisition and short term storage during therapy for a Member with a covered illness
 - Short-term storage of umbilical cord blood for a Member with a malignancy undergoing treatment when there is a donor match.
 - Post-transplant care and treatment
 - Drugs (including immunosuppressive drugs)
 - Supplies (must be Prior Authorized)
 - Psychological testing
 - Living donor transplant-related complications for sixty (60) calendar days following the date the organ is removed, if not otherwise covered by donor's own health benefit plan, by another group health plan or other coverage arrangement

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

Not Covered:

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

Anesthesia benefit

Coverage is available for services of an anesthesiologist or other certified anesthesia Provider in connection with a Certified inpatient or outpatient procedure or treatment.

Section 4(c) Emergency services/accidents

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

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

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Benefit Description

What is an Emergency Medical Condition?

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

What is an Urgent Care Situation?

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

What are Post-Stabilization Services?

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

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

Emergency within the Service Area

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

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

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

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

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

Emergency outside the Service Area

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

Coverage will be provided for Emergency Medical Conditions outside of the Service Area (at the Network benefit level) unless the Member

has traveled outside the Service Area for the purpose of receiving such treatment.

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

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

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

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

NO COVERAGE OUTSIDE OF THE UNITED STATES

There is no coverage for Members when traveling outside of the United States. Services both In and Out-of-Network are only covered by the Plan when provided within the United States. Any costs for health care services received when traveling out of the United States are the sole responsibility of the Member.

Not Covered:

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

Ambulance and emergency transportation services benefit

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

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

Certification is required for:

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

Not Covered:

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

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

- This Certificate of Coverage, including your application for coverage and any amendments constitutes your entire contract of insurance.
- All benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 3, *How you get care*, for valuable information about conditions for coverage.
- For more information on additional mental health and substance use disorder benefits provided to Members age 19 or 20 under EPSDT, see *Benefits for Members age 19 or 20*, under Section 4(a).
- You or your Physician must get authorization (Certification) of some services in this Section. The benefit description will say “**NOTE:** Authorization (Certification) is required for certain services. Failure to get authorization (Certification) will result in a reduction or denial of benefits (See Services requiring authorization (Certification) in Section 3.)”

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Benefit Description

Mental health benefit

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

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

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

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

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

Region I, Williston:

Crisis Line: (701) 572-9111

Toll-Free Crisis Line: (800) 231-7724 | TTY: 711

Region II, Minot:

Crisis Line: (701) 857-8500

Toll-Free Crisis Line: (888) 470-6968 | TTY: 711

Region III, Devils Lake:

Crisis Line: (701) 662-5050 [collect calls accepted]

Toll-Free: (888) 607-8610 | TTY: 711

Region VI, Grand Forks:

Crisis Line: (701) 775-0525

Toll-Free: (800) 845-3731 | TTY: 711

Region V, Fargo:

Crisis Line: (701) 298-4500

Toll-Free: (888) 342-4900 | 211 Helpline | TTY: 711

Region VI, Jamestown:

Crisis Line: (701) 253-6304 | TTY: 711

Region VII, Bismarck:

Crisis Line: (701) 328-8899

Toll-Free: (888) 328-2112 | TTY: 711

Region VIII, Dickinson:

Crisis Line: (701) 290-5719 | TTY: 711

Additional mental health services covered for Members ages 19 and 20

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

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

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

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

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

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

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

Not Covered:

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

Substance use disorder benefit

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

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

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

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

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

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

- All Inpatient services, including those provided by a Hospital or a Residential Treatment Facility
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Not Covered:

- *Confinement Services to hold or confine a Member under chemical influence when no Medically Necessary services are provided, regardless of where the services are received (e.g. detoxification centers)*
 - *Room and board charges for Members ages 21 and over at a Residential Treatment Facility*
 - *Inpatient Treatment for Members ages 21 and over at a Facility that is an Institution for Mental Diseases (IMD)*
 - *Marriage counseling, pastoral counseling, financial or legal counseling, and custodial care counseling*
 - *Educational or non-medical services provided under the Individuals with Disabilities Education Act (IDEA)*
 - *Educational or non-medical services related to learning disabilities, unless medically necessary for Members age 19 or 20*
 - *Services related to environmental change, unless medically necessary for Members age 19 or 20*
 - *Milieu therapy*
 - *Sensitivity training*
 - *Domiciliary care or Maintenance Care*
 - *Convalescent care or Custodial Care*
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Section 4(e) Outpatient prescription drug benefits

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

- This Certificate of Coverage, including your application for coverage and any amendments, constitutes your entire contract of insurance.
- You or your Physician must get authorization (Certification) of some services in this Section.

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Benefit Description

Retail outpatient pharmacy benefits are administered by the North Dakota Department of Human Services (DHS), and NOT by Sanford Health Plan.

Certain medications in the State of North Dakota’s Medicaid Preferred Drug List (PDL) require authorization.

If you have questions about your pharmacy benefit, please call ND DHS at please call ND DHS at 1-800-755-2604 | TTY: 711.

- **Who can prescribe drugs and medications.** You must obtain the prescription from a Provider enrolled with North Dakota Medicaid. If you choose to obtain a prescription from a Provider not enrolled with North Dakota Medicaid, you must pay 100% of the costs of the medication to the pharmacy.
- **Where you can obtain them.** You must fill the prescription at a Pharmacy enrolled with North Dakota Medicaid. If you choose to go to a Pharmacy not enrolled with North Dakota Medicaid, you must pay 100% of the costs of the medication to the Pharmacy.
- **How you can obtain them.** You must present your North Dakota Medicaid ID card to the Pharmacy or your Pharmacy must have your North Dakota Medicaid ID number. If you do not have your North Dakota Medicaid ID Card or ID Number to confirm eligibility, the Pharmacy may ask you to pay 100% of the costs of the medication to the pharmacy.

NOTE: Certain outpatient pharmacy benefits may be or are required to be provided through an outpatient setting such as a provider’s office. These services are administered through Sanford Health Plan as medical claims. Any of the services which require Authorization (Certification) would need to be obtained through Sanford Health Plan and Authorization (Certification) should be obtained prior to receiving services.

| Service | ID Card to Use? | Who Pays the Bill? |
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| <ul style="list-style-type: none"> • Prescriptions I get filled at my local pharmacy | ND Medicaid ID Card | Medicaid through ND Department of Human Services – Pharmacy Benefit |
| <ul style="list-style-type: none"> • Medications I get during a visit to the doctor • Vaccines I get from a pharmacist at the pharmacy • Medications given to me while I am staying overnight at the hospital | Sanford Health Plan ID Card | Sanford Health Plan – Medical Benefit |

Section 4(f) Dental benefits

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

- This Certificate of Coverage, including your application for coverage and any amendments constitutes your entire contract of insurance.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.
- We cover Hospitalization for dental procedures only when a non-dental physical impairment exists, which makes Hospitalization necessary to safeguard the health of the Member. See Section 4(b) for inpatient Hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 3, *How you get care*, for valuable information about conditions for coverage.
- You or your Physician must get authorization (Certification) of some services in this Section. The benefit description will say “**NOTE:** Authorization (Certification) is required for certain services. Failure to get authorization (Certification) will result in a reduction or denial of benefits (See Services requiring authorization (Certification) in Section 3.)”

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Benefit Description

NOTE: The following indicated benefits are Outpatient Surgeries, Service, or DME that require authorization (Certification); failure to get authorization (Certification) will result in a reduction or denial of benefits (See *Services that Require Authorization (Certification)* in Section 3). Dental benefit coverage is as follows:

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

Additional dental services covered for Members ages 19 and 20

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

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

DIAGNOSTIC SERVICES FOR MEMBERS AGE 19 OR 20

- Routine oral evaluations allowed twice during calendar year.
- Bitewing X-rays allowed once annually except when part of a full mouth survey
- Full mouth survey allowed once every 3 years
- Panoramic film allowed once every 3 years
- Intraoral periapical X-rays

PREVENTIVE SERVICES FOR MEMBERS AGE 19 OR 20

- Prophylaxis allowed 4 times during a calendar year
- Topical fluoride applications allowed twice during a calendar year
- Sealants on unfilled, undecayed permanent molars and bicuspid. Benefits are limited to a lifetime maximum of *two (2)* sealants per tooth
- Space maintainers

RESTORATIVE SERVICES FOR MEMBERS AGE 19 OR 20

- Fillings (pin-retention; limit 2)
- Inlays, onlays and Crowns (not part of a fixed partial Denture). Replacement of lost or defective inlays, onlays or Crowns is allowed once every 5 years
- Veneers other than cosmetic are allowed once every 5 years

ENDODONTIC SERVICES FOR MEMBERS AGE 19 OR 20

- Pulpotomy, pulp capping, root canal therapy, apicoectomy, root amputation, hemisection, bleaching of endodontically treated anterior permanent teeth

PERIODONTICS FOR MEMBERS AGE 19 OR 20

- Surgical Periodontic evaluation once for each course of treatment
- Gingivectomy, Gingival Curettage, mucogingival surgery, osseous surgery
- Periodontal scaling and root planing

PROSTHODONTICS (removable & fixed) FOR MEMBERS AGE 19 OR 20

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

ORAL AND MAXILLOFACIAL SURGERY FOR MEMBERS AGE 19 OR 20

- Simple extractions
- Surgical extractions, including removal of impacted wisdom teeth
- Oral Maxillofacial Surgery including fracture and dislocation treatment, frenectomy and cyst and abscess diagnosis and treatment

MEDICALLY NECESSARY ORTHODONTICS FOR MEMBERS AGE 19 OR 20

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

ADJUNCTIVE GENERAL SERVICES FOR MEMBERS AGE 19 OR 20

- Palliative (Emergency) treatment of dental pain
- Anesthesia services
- Occlusal guard for treatment of Bruxism allowed once every 3 years

NOTE: Anesthesia and Hospitalization charges (*This is an Outpatient Service that requires Certification.*) for dental care are covered for a Member who:

- a. is severely disabled or otherwise suffers from a developmental disability, or
- b. has a high-risk medical condition(s), as determined by a licensed Physician, which places such a person at serious risk.

Not Covered:

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

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

- This Certificate of Coverage, including your application for coverage and any amendments, constitutes your entire contract of insurance.
- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 3, *How you get care*, for valuable information about conditions for coverage.
- **YOU MUST GET AUTHORIZATION (CERTIFICATION) PRIOR TO OBTAINING THESE SERVICES:** failure to get authorization (Certification) will result in a reduction or denial of benefits. Call the Sanford Health Plan Transportation Coordinator toll-free at (800) 236-4907 or TTY: 711. See the benefit description below for more information.

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Benefit Description

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

For Prior-Authorization Transportation Requests, call the Sanford Health Plan Transportation Coordinator toll-free at (800) 236-4907 or TTY: 711.

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

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

The following conditions apply:

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

Non-emergency transportation and travel benefit details

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

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

In-State Travel

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

Out-of-State Travel

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

Plan Payment

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

Meals

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

Lodging

Plan payment for lodging is allowed only when medical services or transportation arrangements require a Member to be away overnight. All requests for reimbursement must have authorization (Certification) from Sanford Health Plan.

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| <p>NOTE: Per federal and state regulations, Members will not be reimbursed by the Plan for any payments made by members directly to Providers.</p> |
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Not Covered:

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

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

- All benefits are subject to the definitions, limitations and exclusions in this Certificate of Coverage and are payable only when we determine they are Medically Necessary.
- Be sure to read Section 3, *How you get care*, for valuable information about conditions for coverage.
- **YOU MUST GET AUTHORIZATION (CERTIFICATION) PRIOR TO OBTAINING THESE SERVICES:** failure to get authorization (Certification) will result in a reduction or denial of benefits. See Services requiring authorization (Certification) in Section 3.

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This Certificate of Coverage DOES NOT include Out-of-Network benefits.

Covered Services received Out-of-Network must meet the criteria for Network Coverage as noted within Section 3.

If you choose to receive Covered Services from an Out-of-Network Provider without a reason for Network Coverage, you will be responsible for all financial charges from that Provider.

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

Section 5. Limited and Non-Covered Services

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

General Exclusions

1. Health Care Services provided by an Out-of-Network Provider, unless authorization (Certification) is obtained from the Plan prior to services being provided or if there is an emergency or urgent care situation
2. Health Care Services, including pharmaceutical and outpatient drug benefits, provided prior to the effective date of the Member's coverage with the Plan, or subsequent to the date coverage is terminated by the State of North Dakota
3. Health Care Services performed by any Provider who is a Member of the Member's immediate family, including any person normally residing in the Member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area. If the immediate family member is the only Network Provider in the area, the Member may go to an Out-of-Network Provider and receive Network coverage (Section 3, *Appropriate Access*). If the immediate family member is not the only Network Provider in the area, the Member must go to another Network Provider in order to receive coverage at the Network level
4. Health Care Services covered by any governmental agency/unit for military service-related injuries/diseases, unless applicable law requires the Plan to provide primary coverage for the same
5. Health Care Services for injury or disease due to voluntary participation in a riot, unless source of injury is a result of domestic violence or a medical condition
6. Health Care Services for sickness or injury sustained in the commission of a felony, unless source of injury is a result of domestic violence or a medical condition
7. Health Care Services prohibited state or federal rule, law, or regulation
8. Liposuction, gastric balloons, or wiring of the jaw (unless otherwise related to a covered injury or illness)
9. Voluntary or involuntary drug testing unless a part of a Plan approved treatment plan
10. Any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless medically necessary and otherwise covered under this Certificate of Coverage
11. Therapy and service animals, including those used for emotional or anxiety support
12. Services for which the Member has no legal obligation to pay or for which no charge would be made if the Member did not have health plan or insurance coverage.
13. Services that are the responsibility of a Third-Party Payor or are not billable to health insurance
14. Subsequent surgeries when no tangible evidence of Medical Necessity or improved quality of life exist
15. Complications resulting from non-covered or denied health care services
16. Health Care Services that the Plan determines are not Medically Necessary
17. Experimental and Investigational Services
18. Services that are not Health Care Services
19. Charges for telephone calls to or from a Physician, Hospital or other medical Practitioner/Provider or electronic consultations
20. Services not performed in the most cost-efficient setting appropriate for the condition based on medical standards and accepted practice parameters of the community, or provided at a frequency other than that accepted by the medical community as medically appropriate
21. Charges for duplicating and obtaining medical records from *Out-of-Network Providers* unless requested by the Plan
22. Charges for sales tax, mailing, interest and delivery
23. Charges for services determined to be duplicate services by the Plan Chief Medical Officer or designee
24. Charges that exceed the *Maximum Allowed Amount* for Out-of-Network Providers
25. Services to assist in activities of daily living
26. Alternative treatment therapies including, but not limited to: acupuncture, acupressure, biofeedback, chelation therapy, massage therapy unless covered per Plan guidelines under WHCRA for mastectomy/lymphedema treatment, naturopathy, homeopathy, holistic medicine, hypnotism, hypnotherapy, hypnotic anesthesia, sleep therapy (except for treatment of obstructive apnea), or therapeutic touch
27. Education Programs or Tutoring Services (not specifically defined elsewhere) including, but not limited to, education on self-care or home management
28. Lifestyle Improvement Services, such as physical fitness programs, health or weight loss clubs or clinics
29. Services by a vocational residential rehabilitation center, a community reentry program, halfway house or group home
30. Any services or supplies for the treatment of obesity that do not meet the Plan's medical necessity coverage guidelines, including but not limited to: dietary regimen (except as related to covered nutritional counseling), nutritional supplements, or food supplements, and/or weight loss or exercise programs
31. Panniculectomy or sequela (i.e. anemia, breast reduction, hernia repair, gallbladder removal) as result of gastric bypass surgery that do not meet criteria for medical necessity
32. Cosmetic Services and/or supplies to repair or reshape a body structure primarily for the improvement of a Member's appearance and/or not medically necessary, including but not limited to, breast augmentation, treatment of gynecomastia and any related reduction services, skin disorders, rhinoplasty, liposuction, scar revisions, and cosmetic dental services
33. Removal of skin tags
34. Food items for medical nutrition therapy (except as specifically allowed in the Covered Benefits Section of this Certificate of Coverage)

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35. Any fraudulently billed charges or services received under fraudulent circumstances
 36. Never Events, Avoidable Hospital Conditions, or Serious Reportable Events. Network Providers are not permitted to bill Members for services related to such events.
 37. Autopsies, unless the autopsy is at the request of the Plan in order to settle a dispute concerning provision or payment of benefits. The autopsy will be at the Plan's expense.
 38. Iatrogenic condition illness or injury as a result of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor hand writing resulting in a treatment error. Charges related to iatrogenic illness or injury are not the responsibility of the Member.
 39. Health services received outside of the United States.
 40. Room and board charges for Members ages 21 and over at a Residential Treatment Facility
 41. Inpatient treatment for Members ages 21 and over at a Facility that is an Institution for Mental Diseases (IMD)
 42. Provider-administered drugs in an outpatient setting that are not eligible for federal rebates per CMS guidelines
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Special situations affecting coverage

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

- a. Declared or undeclared acts of War or Terrorism;
- b. Riot;
- c. Civil insurrection;
- d. Major disaster or unforeseen natural events which materially interfere with the ability to provide Health Care Services;
- e. Epidemic or the inability to obtain vaccines or medicines due to circumstances beyond the control of the Plan; or
- f. A labor dispute not involving the Plan Network Providers, the Plan will use its best efforts to arrange for the provision of Covered Services within the limitations of available facilities and personnel. If provision or approval of Covered Services under this Contract is delayed due to a labor dispute involving the Plan or Network Providers, Non-Emergency Care may be deferred until after resolution of the labor dispute.

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

Services covered by other payors

The following are excluded from coverage:

1. Health services for which other coverage is either (1) required by federal, state or local law to be purchased or provided through other arrangements or (2) has been made available to and was purchased by the Covered Person. Examples include coverage required by workers' compensation, no-fault auto insurance, medical payments coverage, or similar legislation. The Plan is not issued in lieu of nor does it affect any requirements for coverage by Workers' Compensation. For injuries or sickness which are job, employment or work related, under which benefits are paid by under any Workers' Compensation or Occupational Disease Act or Law, this Plan contains a limitation which states that such health services are excluded from coverage by the Plan. However, if benefits are paid by the Plan and it is determined that the Member is eligible to receive Workers' Compensation for the same incident; the Plan has the right to recover any amounts paid. As a condition of receiving benefits on a contested work or occupational claim, Member agrees to reimburse the Plan the full amount, which the Plan has paid for Health Care Services when entering into a settlement or compromise agreement relating to compensation for the Health Care Services covered by Workers' Compensation, or as part of any Workers' Compensation Award. The Plan reserves its right to recover against Member even though:
 - a. The Workers' Compensation benefits are in dispute or are made by means of settlement or compromise; or
 - b. No final determination is made that the injury or sickness was sustained in the course of or resulted from employment;
 - c. The amount of Workers' Compensation for medical or health care is not agreed upon or defined by Member or the Workers' Compensation carrier; or
 - d. The medical or health care benefits are specifically excluded from the Workers' Compensation settlement or compromise.Member will not enter into a compromise or hold harmless agreement relating to any work-related claims paid by the Plan, whether or not such claims are disputed by the Workers' Compensation insurer, without the express written agreement of the Plan.
 2. Health Care Services received directly from Providers employed by or directly under contract with the Member's employer, mutual benefit association, labor union, trust, or any similar person or group.
 3. Health Care Services for injury or sickness for which there is other non-group insurance providing medical payments or medical expense coverage, regardless of whether the other coverage is primary, excess, or contingent to the Plan. If the benefits subject to this provision are paid for or provided by the Plan, the Plan may exercise its Rights of Subrogation.
 4. Health Care Services for conditions that under the laws of This State must be provided in a governmental institution.
 5. Health Care Services covered by any other governmental health benefit program such as Medicare, Traditional (FFS) Medicaid, ESRD and/or TRICARE (active duty), unless applicable law requires the Plan to provide primary coverage for the same.
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Services and payments that are the responsibility of Member

1. Out-of-pocket costs, including Copays, are the responsibility of the Member, in accordance with the Member's Summary of Benefits and Coverage (SBC). Additionally, the Member is responsible to a Provider for payment for Non-Covered Services;
 2. Finance charges, late fees, charges for missed appointments and other administrative charges; and
 3. Services for which a Member is either legally, or as customary practice, required to pay in the absence of a group health plan or other
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coverage arrangement.

Section 6. How services are paid for by the Plan

Network Coverage Reimbursement of Charges

When a Member receives Covered Services meeting the criteria for Network Coverage (refer to Network Coverage under Section 3), you will not have to file claims. You will need to present your identification card and pay your Copay, if applicable.

The Plan will pay the Network or Out-of-Network Provider directly, and the Member will not have to submit claims for payment. In this case, at the time of service the Member's only payment responsibility is to pay the Network or Out-of-Network Provider any Copay amount that is required for that service. Providers agree to accept either Sanford Health Plan's payment arrangements or its negotiated contract amounts as full and final payment. Providers who receive full and final payment from Sanford Health Plan are not allowed to balance bill the Member for any remaining charge pursuant to 42 CFR § 447.15, except for any Copay amounts.

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

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

Out-of-Network Coverage Reimbursement of Charges

This Certificate of Coverage DOES NOT include benefits for Out-of-Network Coverage. Covered Services received Out-of-Network must meet the criteria for Network Coverage (refer to Network Coverage under Section 3 and Section 10). If you choose to receive Covered Services from an Out-of-Network Provider without authorization (Certification) from the Plan, you may be responsible for all financial charges from the provider.

Timeframe and Payment of Claims

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

When a Member receives Covered Services from an Out-of-Network Provider and payment is to be made according to Plan guidelines, the Plan will arrange for direct payment to the Out-of-Network Provider, per Plan policy. If the Provider refuses direct payment, the Plan reserves the right to make alternative arrangements to payment.

Payment for Air Ambulance Charges

As a safeguard for Members, Out-of-Network air ambulance services will be reimbursed the Sanford Health Plan Out-of-Network State of North Dakota Medicaid Expansion Rate.

A claim made by the Member for Out-of-Network air ambulance services provided by an air ambulance provider licensed by the North Dakota Health Department will be paid in accordance with the above method. A payment made in accordance with this policy is the same as a Network payment for services and is considered a full and final payment by the Member for Out-of-Network air ambulance services billed to the insured. Providers who receive full and final payment from Sanford Health Plan are not allowed to balance bill the Member for any remaining charges pursuant to 42 CFR § 447.15.

If you have questions, please call our Customer Service Department.

When we need additional information

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

Section 7. Problem Resolution

Member Appeal and Complaint Procedures

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

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

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

Clinical Expertise and Decision Making

Individuals who make decisions on complaints (grievances) and appeals are individuals who are:

1. Neither involved in any previous level of review or decision-making nor are a subordinate of any such individual.
2. Have the appropriate clinical expertise in treating the member's condition or disease.

Audit Trails

Audit trails for Complaints, Adverse Benefit Determinations, and Appeals are provided by the Plan's Information System, which includes documentation of the Complaints, Adverse Benefit Determination and/or Appeals by date, service, procedure, substance of the Complaint/Appeal (including any clinical aspects/details, and reason for the Complaint, Adverse Benefit Determination and/or Appeal. The Appeal file includes telephone notification and documentation indicating the date, the name of the person spoken to, the Member; the service, procedure or admission certified, and the date of the service, procedure, or Adverse Benefit Determination, and reason for determination. If the Plan indicates authorization (Certification) by use of a number, the number will be called the "authorization number."

Definitions

Adverse Benefit Determination: Means the:

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

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

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

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

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

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

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

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

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

In determining whether a request is "Urgent," the Plan shall apply the judgment of a Prudent Layperson as defined in Section 10. When a

Practitioner with knowledge of the Member's medical condition determines a request to be an Urgent Care Situation, the Plan shall treat the prospective review as an Urgent Care Request.

Complaint (Grievance) Procedures

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

The Appeals and Denials Department will make every effort to investigate and resolve all Complaints. Notification of the results will be sent to the Member, and as applicable: Practitioner/Provider, Authorized Representative, legal representative of a deceased Member's estate, and/or attorney within *ninety (90) calendar days* of the Complaint filing date. Customer Service can be reached toll-free at (855) 305-5060 | TTY: 711. The Appeals and Denials Department may be reached toll-free at (877) 652-8544 | TTY: 711, For more information on help provided by the Plan, see *Special Communication & Language Access Services* in the Introduction section of this Certificate of Coverage.

Complaint Acknowledgement

A Member, Member's Authorized Representative (as designated in writing by the Member), and/or the Member's Practitioner/Provider may initiate a Complaint either orally or in writing. The Plan will acknowledge receipt of each Complaint within 72 hours of receipt. Members will be notified by the Plan upon receipt of the Complaint and upon conclusion of the Plan's investigation (no later than 90 calendar days from the date the Complaint was received).

Submitting Complaints (Grievances)

A complainant may orally submit a Complaint to the Customer Service or Appeals and Denials Department. A complaint may also be submitted in writing. A complainant can seek further review of a Complaint not resolved by phone by optionally choosing to submit the written Complaint form. Upon request, the Appeals and Denials department will provide assistance in submitting the Complaint form. **A written complaint form is not required in order for a Member to file a complaint with the Plan.**

The date of the oral inquiry seeking to Complain will be the established Complaint filing date.

A Member, or his/her Authorized Representative, may send the completed a complaint in writing or a completed Complaint form, including comments, documents, records and other information relating to the Complaint, the reasons they believe they are entitled to benefits, and any other supporting documents to:

Sanford Health Plan
Appeals and Denials Department
PO Box 91110
Sioux Falls, SD 57109-1110

or Fax: (605) 312-8910

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

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

Complaint Investigation Procedures and Notification Timelines

The following procedures apply when the Plan receives a complaint:

1. The Plan will acknowledge receipt of each Complaint.
2. Upon request and at no charge, the complainant will be given reasonable access to and copies of all documents, records and other information relevant to the Complaint.
3. The Appeals and Denial Department will investigate and review all Complaints and notify the complainant of Sanford Health Plan's decision in accordance with the following timelines:
 - a. A decision and written notification on the Complaint will be made to the complainant, his or her Practitioners/Providers involved in the provision of the service within *ninety (90) calendar days* from the date the Plan receives your request.
 - b. In certain circumstances, the time period may be extended by up to *fourteen (14) calendar days* if (1) The Member requests the extension; or (2) The Plan shows (to the satisfaction of ND DHS, upon its request) that there is need for additional information and how the delay is in the Member's interest. In such cases, the Plan will notify the complainant in advance, of the reasons for the extension.
 - c. Any complaints related to the quality of care received are subject to practitioner review. If the complaint is related to an Urgent clinical matter, it will be handled in an expedited manner and a response will be provided within *seventy-two (72) hours*.
4. The investigation shall take into account all comments, documents, records, and other information submitted by the Member, without regard to whether such information was submitted or considered in any initial benefit determination.
5. Results of the investigation will be provided to the Member and any other applicable parties no later than *ninety (90) calendar days* after the Complaint is received by the Plan.

Unresolved Appeals

If an Appeal is not resolved to the Member's satisfaction, the Member, and/or his/her Authorized Representative, has the right to file a

complaint. Appeal Rights may be requested by calling the Appeals and Denials Department toll-free at (877) 652-8544 | TTY: 711, 8:00 am to 5:00 pm, Central Time, Monday through Friday. To contact Sanford Health Plan in a language other than English, call (800) 892-0625 (*toll-free*). Language assistance services are free of charge.

Grievances regarding a denial of a request for an expedited resolution of an appeal, or grievances that involve clinical issues, are reviewed by health care professionals who have the appropriate clinical expertise.

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

Appeal Procedures

Types of Appeals

1. A **Prospective (Pre-Service) Appeal** is a request to change an Adverse Benefit Determination, in whole or in part, in advance of the Member obtaining care or services.
2. A **Retrospective (Post-Service) Appeal** is a request to change an Adverse Benefit Determination for care or services already received by the Member.
3. An **Expedited Appeal (Urgent Care Request)** is a request to change a previous Adverse Benefit Determination made by Sanford Health Plan. If the Member's situation meets the definition of Urgent, a determination will be made within *seventy-two (72) hours*.

Continued Coverage for Concurrent Care

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

1. Within *ten (10) calendar days* of the Plan mailing the notice of Adverse Benefit Determination; or
2. The intended effective date of the Plan's determination.

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

Internal Appeal of Adverse Benefit Determination (Denial)

Filing Deadline

Appeals by a Member or Provider and/or Practitioner must be made within *sixty (60) calendar days* from the date printed on the notification of the Adverse Benefit Determination.

Within *sixty (60) calendar days* after the date printed on the notice of an Adverse Benefit Determination sent to a Member, or the Member's Authorized Representative (as designated in writing by the Member), the Member, or their Authorized Representative, may file an Appeal with the Plan requesting a review of the Adverse Benefit Determination.

The Member or the Authorized Representative should contact the Plan by calling (877) 652-8544 (*toll-free*) | TTY: 711 or writing: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. Appeals can also be filed online through your secure mySanfordHealthPlan member account at www.sanfordhealthplan.com/memberlogin.

If a Member needs assistance in filing an Appeal, they should call the Health Plan toll-free at (877) 652-8544 or TTY: 711. For more information on help provided by the Plan, see *Special Communication & Language Access Services* in the Introduction Section of this Certificate of Coverage. For free help in a language other than English, call (800) 892-0675.

Appeal Acknowledgement

A Member, Member's Authorized Representative (as designated in writing by the Member), and/or the Member's Practitioner/Provider may initiate an Appeal either orally or in writing. The date of the oral inquiry seeking an Appeal will be the established Appeal filing date.

The Plan will acknowledge each Appeal request within *72 hours* of receipt. Members will be notified by the Plan upon receipt of the Appeal and upon the Plan's decision on the Appeal.

Internal Appeal Determination Notice Content

The written decision for Internal Appeals will contain the following information:

1. The results and date of the Appeal Determination;
2. The specific reason for the Adverse Benefit Determination in easily understandable language;
3. The titles and qualifications, including specialty, of the person or persons participating in the first level review process (Reviewer names are available upon request);
4. Reference to the evidence, benefit provision, guideline, and/or protocol used as the basis for the decision and notification that the Member on request can have a copy of the actual benefit provisions, guidelines, and protocols free of charge;
5. If the Adverse Benefit Determination is regarding coverage for a mental health and/or substance use disorder, a statement notifying Members of their opportunity to request treatment and diagnosis code information free of charge;

6. Notification the Member can receive, upon request and free of charge, reasonable access and copies of all documents, records and other information relevant to the Member's appeal request;
7. Statement of the reviewer's understanding of the Member's Appeal;
8. The Reviewer's decision in clear terms, and the contract basis, or medical rationale, in sufficient detail for the Member to respond further;
9. If the Adverse Benefit Determination is based on medical necessity, notification and instructions on how the Practitioner/Provider can contact the Physician or appropriate practitioner to discuss the determination;
10. If the Adverse Benefit Determination is based on medical necessity or an Experimental or Investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for making the determination, applying the terms of the Plan to the Member's medical circumstances or a statement that an explanation will be provided to the Member free of charge upon request;
11. If applicable, instructions for requesting:
 - a. A copy of the rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; or
 - b. The written statement of the scientific or clinical rationale for the determination;
12. Notice of the right to initiate the External Review process for Adverse Benefit Determinations based on medical necessity. Refer to "Independent, External Review of Final Determinations" in this Section for details on this process. Final Adverse Benefit Determination letters from the Plan will contain information on the circumstances under which Appeals are eligible for External Review and information on how the Member can seek further information about these rights; and
13. If the Adverse Benefit Determination is completely overturned, the determination notice will state the decision and the date.
14. **For Adverse Benefit Determinations of Prospective (Pre-service) or Retrospective (Post-service) Reviews:** a statement indicating:
 - a. The written procedures governing the standard internal review, including any required timeframe for the review; and
 - b. For decisions not wholly in the Member's favor, the right to request a State Fair Hearing and how to request a State Fair Hearing within *one hundred and twenty (120) calendar days*;
 - c. If the timeline is extended for an appeal and it is not at the request of the Member, the Plan will make reasonable efforts to give the Member prompt oral notice of the delay and give the Member written notice within *two (2) calendar days* of the reason for the decision to extend the timeframe and inform the Member of the right to file a grievance if he or she disagrees with the Plan's decision to extend the decision time. Timelines may only be extended if (1) The Member requests the extension; or (2) The Plan shows (to the satisfaction of ND DHS, upon its request) that there is need for additional information and how the delay is in the Member's interest.

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

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

1. The Member shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits. Members, Authorized Representatives, and/or Practitioners/Providers have the right to present evidence in person.
2. The Member shall be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by, or at the direction of, Sanford Health Plan in connection with the claim; and such evidence shall be provided as soon as possible and sufficiently in advance of the date on which the notice of final internal Adverse Benefit Determination is required to be provided to give the Member a reasonable opportunity to respond prior to that date.
3. Confirm with the Member whether additional information will be provided for Appeal review. The Plan will document if additional information is provided or no new information is provided for Appeal review.
4. Before Sanford Health Plan can issue a final Adverse Benefit Determination based on a new or additional rationale, the Member will be provided, free of charge, with the rationale; the rationale will be provided as soon as possible and sufficiently in advance of the date on which the notice of Adverse Benefit Determination is required to be provided and give the Member a reasonable opportunity to respond prior to the date.
5. The Member shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Member's initial request.
6. For Mental Health and/or Substance Use Disorder (MH/SUD) Adverse Benefit Determinations, if information on any medical necessity criteria is requested, documents will be provided for both MH/SUD and medical/surgical benefits within *thirty (30) calendar days* of a Member/Member's Authorized Representative/Provider's request. This information will include documentation of processes, strategies, evidentiary standards and other factors used by the Plan, in compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA);
7. The review shall take into account all comments, documents, records, and other information submitted by the Member relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.
8. Full and thorough investigation of the substance of the Appeal, including any aspects of clinical care involved, will be coordinated by the appropriate Plan personnel.
9. The Plan will document the substance of the Appeal, including but not limited to, the Member's reason for appealing the previous decision and additional clinical or other information provided with the Appeal request. The Plan will also document any actions taken, including but not limited to, previous denial or appeal history and follow-up activities associated with the denial and conducted before the current Appeal.
10. The review shall not afford deference to the initial Adverse Benefit Determination; and shall be conducted by a named Plan

representative, who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal nor the subordinate of such individual.

11. In deciding an Appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Plan shall consult with a health care professional (same-or-similar specialist) who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care Practitioner/Provider engaged for purposes of a consultation under this paragraph shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of any such individual.
12. The Plan shall identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Member's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit request determination.
13. In order to ensure the independence and impartiality of the persons involved in making claims determinations and Appeals decisions, all decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) shall not be made based upon the likelihood that the individual will support the denial of benefits.
14. The attending Practitioner/Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Appeal within *seventy-two (72) hours* of the Plan's receipt of the Appeal.
15. Sanford Health Plan will provide notice of any Adverse Benefit Determination in a manner consistent with applicable federal regulations.

Standard (Non-Urgent) Appeal Decision Notification Timeframes

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

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

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

Expedited (Urgent) Appeal Procedure

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

Timeframes

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

The Member and those Practitioners/Providers involved in the Appeal will receive written notification within *twenty-four (24) hours* of the oral notification. If your request for an Expedited Appeal review is denied, it will be handled in the same manner as a Non-Urgent Pre-Service or a Non-Urgent Post-Service Appeal, depending upon the type of denial being appealed.

The standard timeframe for non-Urgent Appeal determinations is *thirty (30) calendar days*, with a possible *fourteen (14) calendar day* extension if (1) The Member requests the extension; or (2) The Plan shows (to the satisfaction of ND DHS, upon its request) that there is need for additional information and how the delay is in the Member's interest, for resolving the appeal and providing notice of the appeal resolution. Members may file a complaint (grievance) if they disagree with the decision to extend the time allowed for issuing the decision.

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

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

The Plan will follow the procedure for providing independent, external review of final determinations in accordance with guidelines set forth

by North Dakota Department of Human Services Medical Services Division. Accordingly, upon exhaustion of the Plan's internal appeals process, a Member may pursue an external review of a final Adverse Benefit Determination by requesting a State Fair Hearing with the North Dakota Department of Human Services.

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

State Fair Hearing Request Procedures

External Review Requests

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

Appeals Supervisor, Legal Advisory Unit

N.D. Department of Human Services

600 E Boulevard Avenue, Dept. 325

Bismarck, ND 58505-0250

Email: dhs1au@nd.gov

Phone: (701) 328-2311 | (800) 472-2622 (*toll-free*)

ND Relay TTY: (800) 366-6888

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

1. The right to request a State Fair Hearing within *one hundred and twenty (120) calendar days* from the date of the written Adverse Benefit Determination notice with the following conditions:
 - a. The Member has completed the Internal Appeal process through Sanford Health Plan with the Adverse Benefit Determination being upheld, or
 - b. Sanford Health Plan has failed to adhere to the notice and timing requirements of the Internal Appeal process which then the Member is deemed to have exhausted the Plan's appeal process;
2. How to request a State Fair Hearing;
3. Parties to the State Fair Hearing are a Member, health care Practitioner/Provider with knowledge of the Member's medical condition, Authorized Representative of the Member, legal representative of a deceased Member's estate, and/or an attorney
4. The right to continue to receive benefits pending a hearing with the following conditions:
 - a. The Appeal is filed in a timely manner;
 - b. The Appeal involves the termination, suspension, or reduction of a previously authorized course of treatment;
 - c. The services were ordered by an authorized Provider;
 - d. The period covered by the original authorization has not expired; and
 - e. The Member requests the extension of benefits; and
5. How to request the continuation of benefits. If the Plan continues or reinstates the Member's benefits, the benefits will be continued until one of the following:
 - a. The Member withdraws the Appeal; or
 - b. *Ten (10) calendar days* pass after the Plan mails its Notice of Adverse Benefit Determination (unless the Member has requested continuation of benefits pending a State Fair Hearing decision); or
 - c. A State Fair Hearing officer issues a hearing decision adverse to the Member; or
 - d. The time period or service limit of a previously authorized service has been met; and
6. If the Plan's action is upheld in a hearing, the Member may be liable for the cost of the continued benefits;
7. If the Plan or the State Fair Hearing officer reverses a decision to deny, limit, or delay services that were not furnished while the Appeal was pending, then the Plan will authorize or provide the disputed services promptly, and as expeditiously as the Member's health condition requires; and
8. If the Plan or the State Fair Hearing officer reverses a decision to deny authorization of services and the Member received the disputed services while the Appeal was pending, then the Plan will pay for the disputed services. If overturned by the State Fair Hearing, SHP will authorize or provide the disputed services promptly but no later than *72 hours* from the date we receive notice reversing the determination.

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

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

Section 8. Coordination of Benefits (COB)

When you have other coverage

As a condition of Medicaid eligibility, you must cooperate with identifying and providing information to assist Sanford Health Plan in pursuing third parties who may be liable to pay for care or services. Pursuant to federal and state laws that govern the Medicaid Expansion Program, the Plan is the payor of last resort which means that Sanford Health Plan has the right to deny the payment of benefits if the Member's Covered Services are covered under another health insurance or medical expense policy. Failure to cooperate with out good cause or intentionally falsifying information will be grounds for review by ND DHS Division of Medical Services Fraud and Abuse Administrator and may be referred to Local Law Enforcement or the Health and Human Services Office of Inspector General for allegations of healthcare fraud.

You must report any other health care coverage options you may have or changes in that coverage to the Plan via contacting Customer Service. Having other insurance does not change whether or not you can have Medicaid Expansion coverage, unless you have Medicare or traditional Medicaid coverage. You must report any other insurance so that the Plan stays the payor of last resort.

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

Effect of COB on the benefits of this plan

1. Sanford Health Plan is entitled to:
 - a. Determine whether and to what extent a Member has indemnity coverage or other health benefit coverage for Covered Services; and
 - b. Establish the priorities for determining primary responsibility among the payers including Sanford Health Plan, obligated to provide health care services or indemnity benefits; and
 - c. Require a Member or Provider to file a claim with the primary payer before it determines the amount of Sanford Health Plan payment obligation, if any; and recover from the Member or Provider, as applicable, the expense of Covered Services rendered to a Member to the extent that such services are covered or indemnified by any other payer; and
 - d. Recover from the Member or Provider, as applicable, the expense of services rendered to a Member which are subsequently determined to be Non-Covered Services and were incorrectly provided because of the Member's error.
2. Nothing in this subsection shall be construed to require Sanford Health Plan to make payment until it determines whether it is the primary payer or the secondary payer and what benefits are payable by the primary payer.

Right to receive and release needed information

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

Right of recovery

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

Coordination of benefits with other plans

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

Coordination of benefits with TRICARE

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

1. When a TRICARE beneficiary is covered under this Plan, and also entitled to Medicaid Expansion, TRICARE will be the primary payer, absent other coverage, and this Plan will be tertiary (last).
2. TRICARE-eligible Members receive primary coverage under this Plan's provisions in the same manner, and to the same extent, as similarly situated Members who are not TRICARE eligible.

Sanford Health Plan does not:

1. Provide financial or other incentives for a TRICARE-eligible Member not to enroll (or to terminate enrollment) under the Plan, which would (in the case of such enrollment) be a primary plan (the incentive prohibition); and
2. Deprive a TRICARE-eligible Member of the opportunity receive care as a beneficiary under Medicaid Expansion.

Section 9. Subrogation and Right of Reimbursement

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

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

This Plan may give or obtain needed information from another insurer or any other organization or person. Each and every Covered Individual hereby authorizes the Plan to give or obtain any medical or other personal information reasonably necessary to apply the provisions of Sections 8 and 9.

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

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

Plan’s Rights of Subrogation

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

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

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

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

Plan’s Right to Reduction and Reimbursement

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

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

The Plan shall have a lien on all funds received by the Member, his or her parents, heirs, guardians, executors, or other representatives up to the Maximum Allowed Amount for the Health Care Services provided to the Member.

Erroneous Payments

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

Member’s Responsibilities

1. The Member, Member’s parents, heirs, guardians, executors, or other representatives must take such action, furnish such information and assistance, and execute such instruments as the Plan requires to facilitate enforcement of its rights under this Part. The Member shall take no action prejudicing the rights and interests of the Plan under this provision.
2. Neither a Member nor his or her attorney, or other representative, is authorized to accept subrogation or reimbursement payments on behalf of the Plan, to negotiate or compromise the Plan’s subrogation or reimbursement claim, or to release any right of recovery or

reimbursement without the Plan's express written consent.

3. Any Member who fails to cooperate in the Plan's administration of this Part shall be responsible for the Maximum Allowed Amount for services subject to this section and any legal costs incurred by the Plan to enforce its rights under this Section.
4. The Plan shall have no obligation whatsoever to pay medical benefits for a Member if a Member refuses to cooperate with the Plan's Subrogation and Refund rights, or refuses to execute and deliver such papers as the Plan may require in furtherance of its Subrogation and Refund rights.
5. Members must also report any recoveries from insurance companies or other persons or organizations arising from or relating to an act or omission that caused or contributed to an injury or illness to the Member paid for by the Plan. Failure to comply will entitle the Plan to withhold benefits, services, payments, or credits due under the Plan.

Payment in Error

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

Section 10. Defined terms in this Certificate of Coverage

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

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| Creditable Coverage | Benefits or coverage provided under: a. A group health benefit plan (as such term is defined under North Dakota law); b. A health benefit plan (as defined under state and federal laws); c. Medicare or Medicaid; d. Civilian health and medical program for uniformed services e. A health plan offered under 5 U.S.C. 89; f. A medical care program of the Indian Health Service or of a tribal organization; g. A state health benefits risk pool, including coverage issued under N.D.C.C. ch. 26.1-08; h. A public health plan as defined in federal regulations, including a plan maintained by a state government, the United States government, or a foreign government; i. A health benefit plan under section 5(e) of the Peace Corps Act Pub. L. 87-293; 75 Stat. 612; 22 U.S.C. 2504(e); j. A church plan; or k. A state's children's health insurance program funded through Title XXI of the federal Social Security Act [42 U.S.C. 1397aa et seq.]. |
| Domiciliary Care | Domiciliary Care consists of a protected situation in a community or facility, which includes room, board, and personal services for individuals who cannot live independently yet do not require 24-hour Facility or nursing care. |
| Eligible Individual | Any individual who meets the specific eligibility requirements of this Plan, as determined by the North Dakota Department of Human Services Division of Medical Services. |
| Emergency Care Services | Means: (1) <i>Within the Service Area</i> : covered health care services rendered by Network or Out-of-Network Providers under unforeseen conditions that require immediate medical attention. Emergency care services within the Defined Service Area include covered health care services from Out-of-Network Providers only when delay in receiving care from Network Providers could reasonably be expected to cause severe jeopardy to the Member's condition; or (2) <i>Outside the Service Area</i> : medically necessary health care services that are immediately required because of unforeseen illness or injury while the Member is outside the geographical limits of the Plan's Service Area. |
| Emergency Medical Condition | A medical condition of recent onset and severity, including severe pain, that would lead a prudent layperson acting reasonably and possessing an average knowledge of health and medicine to believe that the absence of immediate medical attention could reasonably be expected to result in serious impairment to bodily function, serious dysfunction of any bodily organ or part, or would place the person's health, or with respect to a pregnant woman the health of the woman or her unborn child, in serious jeopardy |
| Enrollee | An individual who is covered by this Plan. |
| ESRD | The federal End Stage Renal Disease program. |
| Expedited Appeal | An expedited review involving Urgent Care Requests for Adverse Benefit Determinations of Prospective (Pre-service) or Concurrent Reviews will be utilized if the Member, or Practitioner/Provider acting on behalf of the Member, believes that an expedited determination is warranted. |
| Experimental or Investigational Services | Health Care Services where the Health Care Service in question either: a. is not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or b. requires approval by any governmental authority and such approval has not been granted prior to the service being rendered. |
| Facility | An institution providing Health Care Services or a health care setting, including Hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, Skilled Nursing Facilities, Residential Treatment Facilities, diagnostic, laboratory, and imaging centers, and rehabilitation and other therapeutic health settings. |
| Health Care Services | Services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury or disease. |
| Hospital | A short-term, acute care, duly licensed institution that is primarily engaged in providing inpatient diagnostic and therapeutic services for the diagnosis, treatment, and care of injured and sick persons by or under the supervision of Physicians. It has organized departments of medicine and/or major surgery and provides 24-hour nursing service by or under the supervision of registered nurses. The term "Hospital" specifically excludes rest homes, places that are primarily for the care of convalescents, nursing homes, Skilled Nursing Facilities, Residential Care Facilities, custodial care homes, intermediate care facilities, health resorts, clinics, Physician's offices, private homes, Ambulatory Surgical Centers, residential or transitional living centers, or similar facilities |
| Hospitalization | A stay as an inpatient in a Hospital. Each "day" of Hospitalization includes an overnight stay for which a charge is customarily made. Benefits may not be restricted in a way that is based upon the number of hours that the insured stays in the hospital. |

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| Iatrogenic Condition | Illness or injury as a result of mistakes made in medical treatment, such as surgical mistakes, prescribing or dispensing the wrong medication or poor handwriting resulting in a treatment error. |
| Individual Contract | A contract for Health Care Services issued to an individual for coverage under North Dakota Medicaid Expansion. |
| Institution for Mental Diseases (IMD) | A Hospital, institution, or other stand-alone Facility of 17 beds or more that is primarily engaged in providing diagnosis, treatment, or care for people with mental health and/or substance use disorders. Treatment provided to adults in an IMD is not reimbursable with federal dollars. The payment exclusion does not apply to treatment in Facilities that are part of larger medical entities that are not primarily engaged in the treatment of mental health and/or substance use disorders (generally tested by whether the majority of the patient population was admitted and treated for reasons other than mental health and/or substance use disorders), such as general hospitals or skilled nursing facilities. |
| Intensive Outpatient Program (IOP) | Provides mental health and/or substance use disorder outpatient treatment services during which a Member remains in the program a minimum of three (3) continuous hours per day and does not remain in the program overnight. |
| Intermediate Care | Intermediate Care means care in a facility, corporation or association licensed or regulated by the in the state in which it operates for the accommodation of persons, who, because of incapacitating infirmities, require minimum but continuous care but are not in need of continuous medical or nursing services. The term also includes facilities for the nonresident care of elderly individuals and others who are able to live independently but who require care during the day. |
| Maintenance Care | Treatment provided to a Member whose condition/progress has ceased improvement, or could reasonably be expected to be managed without the skills of a Practitioner/Provider. |
| Maximum Allowed Amount | The amount established by Sanford Health Plan using various methodologies for covered services and supplies. Sanford Health Plan's Maximum Allowable Amount is the lesser of: a. the amount charged for a covered service or supply; or b. Network rates with Sanford Health Plan; or c. the Sanford Health Plan Out-of-Network State of North Dakota Medicaid Expansion Rate |
| Medically Necessary or Medical Necessity | Medical or remedial services or supplies required for treatment of illness, injury, diseased condition, or impairment; consistent with the Member's diagnosis or symptoms; appropriate according to generally accepted standards of medical practice; not provided only as a convenience to the Member or Provider; not investigational, experimental, or unproven; clinically appropriate in terms of scope, duration, intensity, and site; and provided at the most appropriate level of service that is safe and effective. <u>For Members 19 or 20 only:</u> Medical Necessity is defined under the EPSDT benefit as a covered service or item if it will do, or is reasonably expected to do, one or more of the following: a. Arrive at a correct medical diagnosis; b. Prevent the onset of an illness, condition or injury or disability in the individual or in covered relatives, as appropriate; c. Reduce, correct, or ameliorate the physical, mental, developmental, or behavioral effects of an illness, condition, injury or disability; and/or d. Assist the individual to achieve or maintain sufficient functional capacity to perform age appropriate or developmentally appropriate daily activities. |
| Member | Any individual who is enrolled in the Plan. |
| Mental Health and/or Substance Use Disorder Services | Health Care Services for disorders specified in the Diagnostic and Statistical Manual of Mental Disorders (DSM), the American Society of Addiction Medicine Criteria (ASAM Criteria), or the International Classification of Diseases (ICD), current editions. Also referred to as behavioral health, psychiatric, chemical dependency, substance abuse, and/or addiction services. |
| Natural Teeth | Teeth, which are whole and without impairment or periodontal disease, and are not in need of the treatment provided for reasons other than dental injury. |
| Network Coverage | Network Coverage applies when Covered Services are received from the following: (1) Network Providers; (2) Out-of-Network Providers who provide emergency or urgent care; (3) Out-of-Network Providers who provide family planning care; or (4) Out-of-Network Providers when access to a Network Provider is not available or feasible, and authorization is obtained from Sanford Health Plan. |

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| Network Provider | Providers who are contracted with Sanford Health Plan or its vendor for the ND Medicaid Expansion Network, enrolled with state of North Dakota Medicaid Program, and located within the Service Area. The following facilities and/or providers are considered Network Providers: Federally Qualified Health Centers (FQHC), Rural Health Clinics (RHC), and Indian Health Care Providers (IHCP). |
| Never Event | Errors in medical care that are clearly identifiable, preventable, and serious in their consequences for Members and that indicate a real problem in the safety and credibility of a health care facility. Network Providers are not permitted to bill the Plan or Members for services related to Never Events. |
| Non-Covered Services | Non-Covered Services are those Health Care Services that: (1) are excluded by this Certificate of Coverage; (2) require prior authorization under the terms of this Certificate of Coverage but not obtained or provided; or (3) are provided by an Out-of-Network Provider that are not emergent or urgent care services. |
| Non-Payable Provider | A Practitioner and/or Provider who is not enrolled with the North Dakota Department of Human Services as payable by a Managed Care Organization (MCO). |
| Nursing Services | Health Care Services which are provided by a registered nurse (RN), licensed practical nurse (LPN), or other licensed nurse who is: (1) acting within the scope of that person's license, (2) authorized by a Provider, and (3) not a Member of the Member's immediate family. |
| Out-of-Network Coverage | Out-of-Network Coverage applies when services are received from an Out-of-Network Provider without a reason for Network Coverage. |
| Out-of-Network Provider | Providers who do not meet all of the criteria as noted within the Network Provider definition. |
| Participating Provider | A Practitioner/Provider who, under a contract with the Plan, or with its contractor or subcontractor, has agreed to provide Health Care Services to Members with an expectation of receiving payment, other than Copays, directly or indirectly, from the Plan. |
| Partial Hospitalization | Also known as day treatment; A licensed or approved day or evening outpatient treatment program that includes the major diagnostic, medical, psychiatric and psychosocial rehabilitation treatment modalities designed for individuals with mental health and/or substance use disorders who require coordinated, intensive, comprehensive and multi-disciplinary treatment. |
| Physician | An individual licensed to practice medicine or osteopathy. |
| [The] Plan | Sanford Health Plan. |
| Practitioner | A professional who provides health care services. Practitioners are licensed as required by law. |
| Preventive | Health Care Services that are medically accepted methods of prophylaxis or diagnosis which prevent disease or provide early diagnosis of illness and/or which are otherwise recognized by the Plan. |
| Primary Care Practitioner (PCP) | A Network Provider who is an Internist, Family Practice Physician, Pediatrician, or Obstetrician/Gynecologist who has been chosen to be designated as a PCP in the Plan's Provider Directory. This person may be responsible for providing, prescribing, directing, referring, and/or authorizing all care and treatment of a Member. Designated Primary Care Practitioners may also include Physician Assistants and Nurse Practitioners. |
| Routine (pre-service) Review | Means Urgent and non-Urgent Utilization Review conducted prior to an admission or the provision of a health care service or a course of treatment. |
| Provider | A practitioner, institution, or organization that provides services for Plan Members. Examples of Providers include Hospitals, health care professionals, and home health agencies. |
| Prudent Layperson | A person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek Emergency medical treatment. |
| Qualified Mental Health Professional | Includes a licensed physician who is a psychiatrist; a licensed clinical psychologist who is qualified for listing on the national register of health service Providers in psychology; a licensed certified social worker who is a board-certified in clinical social work; or a nurse who holds advanced licensure in psychiatric nursing. |

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| Residential Treatment Facility | An inpatient mental health or substance use disorder treatment Facility that provides twenty-four (24) hour availability of qualified medical staff for psychiatric, substance abuse, and other therapeutic and clinically informed services to individuals whose immediate treatment needs require a structured twenty-four (24) hour residential setting that provides all required services on site. Services provided include, but are not limited to, multi-disciplinary evaluation, medication management, individual, family and group therapy, substance abuse education/counseling. Facilities must be under the direction of a board-eligible or certified psychiatrist, with appropriate staffing on-site at all times. If the Facility provides services to children and adolescents, it must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children. Hospital licensure is required if the treatment is Hospital-based. The treatment Facility must be licensed by the state in which it operates. |
| Retrospective (Post-service) Review | Means any review of a request for a benefit that is not a Routine (Pre-service) Review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication of payment. Retrospective (Post-service) Review will be utilized by Sanford Health Plan to review services that have already been utilized. |
| Room and Board | Includes but is not limited to the provision of meals, a place to sleep, laundry, and housekeeping. Room and board are not covered in a Residential Treatment Facility for Members ages 21 and older. |
| Serious Reportable Event | An event that results in a physical or mental impairment that substantially limits one or more major life activities of a Member or a loss of bodily function, if the impairment or loss lasts more than seven (7) calendar days or is still present at the time of discharge from an inpatient health care facility. Serious events also include loss of a body part and death. Network Providers are not permitted to bill Members or the Plan for services related to Serious Reportable Events. |
| Service Area | Under the terms of this certificate of coverage the geographic area where a Member can receive Health Care Services from Network Providers including all counties in the state of North Dakota, and the contiguous (bordering) counties in South Dakota, Montana, and Minnesota. Please see the Service Area noted in the Introduction. |
| Skilled Nursing Facility | A facility that is operated pursuant to the presiding state law and is primarily engaged in providing room and board accommodations and skilled nursing care under the supervision of a duly licensed physician. |
| Subscriber | An Eligible Member who is enrolled in the Plan. A Subscriber is also a Member or Enrollee. |
| [This] State | The State of North Dakota. |
| Urgent Care Request | Means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination: a. Could seriously jeopardize the life or health of the Member or the ability of the Member to regain maximum function, based on a prudent layperson's judgment; or b. In the opinion of a Practitioner/Provider with knowledge of the Member's medical condition, would subject the Member to severe pain that cannot be adequately managed without the health care service or treatment that is the subject of the request. |
| Urgent Care Situation | A degree of illness or injury, which is less severe than an Emergency Condition, but requires prompt medical attention within <i>twenty-four (24) hours</i> , such as stitches for a cut finger. |
| Utilization Review | A set of formal techniques used by the Plan to monitor and evaluate the medical necessity, appropriateness, and efficiency of Health Care Services and procedures including techniques such as ambulatory review, Routine (pre-service) Review, second opinion, Authorization (Certification), Concurrent Review, Case Management, discharge planning, and retrospective (post-service) review. |
| Us/We | Refers to Sanford Health Plan |

Attachment I: Summary of Benefits and Coverage

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