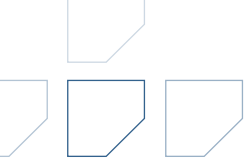




Employer Guide
Group Medical & Prescription
Drug Coverage

SANFORD[®]
HEALTH PLAN



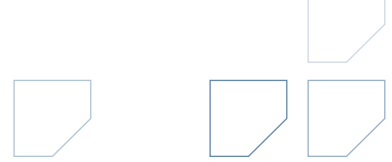


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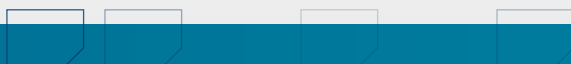
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Welcome to Sanford Health Plan!

We understand that health insurance is one of the largest expenses for your business, and we thank you for selecting Sanford Health Plan.

Keeping employees healthy, before they become ill or injured, is central to our philosophy. The following guide contains information about our products and services—including opportunities designed to help our members maintain healthy lifestyles by promoting education, prevention and early detection of health conditions. Together, we can work toward our mutual objective of maintaining optimum health for you and your employees.

Thank you again for choosing Sanford Health Plan.



The Sanford Health Plan Advantage

Our philosophy

Sanford Health Plan is dedicated to the work of health and healing. Our goal is to serve our clients and members through four areas of focus: **Access**, **Value**, **Wellness** and **Satisfaction**.

Our commitment to you

- Manage health care costs to maintain affordable premiums
- Deliver reports and information useful in planning and decision making
- Assist with educating employees to become engaged health care consumers
- Prompt and accurate claims processing
- Superior customer service
- Centralized web-based tools for your fast and accurate access 24/7



Client Services—We're here to help.

Each client is assigned an associate within our Sanford Health Plan Client Services team. Clients with larger membership are also assigned an Account Executive, providing an enhanced level of service. The Account Executive serves as your liaison to the internal teams at Sanford Health Plan.

In collaboration with your agent, your Account Executive partner will provide:

- Innovative strategies and customized solutions
- Assistance with complex issues or other concerns
- Understanding policy changes and other federal and state regulations affecting health insurance
- Explanation of reports and understanding of the financial health of your insurance benefit plan
- Participation in open enrollment meetings, or company-sponsored health and wellness fairs

Daily operational items such as enrollment variances, ID card orders, or other common questions can be addressed by your associate.

Contact us

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

Department	Services Provided	Phone Number
Enrollment/eligibility	Additions, changes, termination in coverage (status of processing), COBRA inquiries, etc.	(605) 328-6862
Customer service	Claim inquiries, coordination of benefits, order ID cards, benefit questions, complaints/appeals	(800) 752-5863
Care Management	Medical and behavioral health case management and social work services	(888) 315-0884
Flexible spending	FSA, HSA or HRA accounts Administered by HealthEquity	(844) 281-0429
Utilization management	Prior authorization, complex case management, referrals, medical necessity determinations, transplant services, healthy pregnancy program or disease management programs	(800) 805-7938
Pharmacy	Drug formulary or prescription questions	(855) 305-5062
Finance/billing	Premium invoice or payment inquiries	(888) 845-4468
Language line	Help for non-English speaking members	(800) 892-0675
My Sanford Nurse	Health questions or information on appropriate level of care, 24-hours, 7-days-a-week	(888) 315-0886

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

What your employees can expect

ID CARDS

The policyholder (employee) of the coverage will receive one ID card if they have single coverage and two ID cards if others are also on the plan. If two cards are issued, both cards will be in the name of the subscriber. Use the ID card at each provider visit or when filling a prescription. An explanation of the information shown on the card is below for your reference. Employees should receive their ID card(s) before their effective date.

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

Plan and network information (if applicable) ①

Policyholder name ②

Policyholder ID number ③

Group ID number (if applicable) ④

Information shown here means you have prescription drug coverage or are eligible for prescription drug discounts at a participating pharmacy ⑤

Information for your pharmacy (if applicable) ⑥

Call this number with questions about your insurance. ⑪

Information on how to request prior authorization of medical and pharmacy services. You must get authorization for all inpatient and select outpatient procedures, back surgery, home health care, select durable medical equipment (DME), cancer services and treatment, genetic testing, transplants and specialty medication. ⑫

⑦ Office visit copay information

⑧ Go here to find an in-network (participating) provider or pharmacy

⑨ Urgent/emergent care information

⑩ If a logo is printed here, you may have coverage outside the service area. See your plan documents for details.

Claims
Payor ID: 91184
 Sanford Health Plan
 PO Box 91110
 Sioux Falls, SD 57109-1110
If there is an address along with a network logo in the medical section, please submit to that address.

Contact Us
Website:
sanfordhealthplan.com
Customer Service:
 1-800-752-5863
Prior Authorization:
 Medical 1-800-805-7938
 Pharmacy 1-855-305-5062

Eligibility
 You may be asked to present this card when you receive care. This card does not guarantee coverage. You must comply with all terms and conditions of the Plan. Willful misuse of this card is considered fraud.
 For emergency care outside of the Sanford Health Plan Service area, call 911 or go to the nearest emergency facility. Notify Sanford Health Plan of an admission as soon as it is reasonably possible to do so.

HELPING YOUR EMPLOYEES UNDERSTAND THEIR HEALTH INSURANCE

New member welcome program

Within the first 60 days of enrollment, new members will receive a welcome mailer and a series of emails with information on The First 5 - what new members can do to make the most of their health plan.

The First **5**

Here are the first five things you should do to maximize your plan.





ADDITIONAL INFORMATION YOUR EMPLOYEES RECEIVE

Member handbooks/Summary of Benefits and Coverage (SBC)/Certificate of Insurance (COI)

New Sanford Health Plan members will receive a member handbook (specific to the provider network selected) and the Certificate of Insurance (or policy) for their product. These documents will be sent via US postal mail within 30 days of the employee's effective date.

The member handbook will provide information on how to use their ID card, how to navigate our provider network and directory, available care options, which services require pre-authorization and much more. The member will also receive information on where they can obtain their SBC.

Initial COBRA notification

If we administer your COBRA benefits, Sanford Health Plan will send all new members an initial COBRA notification, as required by COBRA regulations.

YOUR EMPLOYEES MAY RECEIVE

Sanford Health Plan may contact your employees and/or their covered dependents for the following reasons:

- **Coordination of benefits:** To process claims efficiently and accurately, we may send a coordination of benefits form to your employee or their family member. This form is sent to ensure there is not another health insurance that we may have to coordinate with for the member's benefits. Members can complete and return the form or contact our customer service department to tell us if they have other health insurance coverage.
- **Transition of care:** Transition of care forms are only accepted within the first 30 days of the group's effective date. Newly hired employees are not allowed transition of care. However, if a new employee is undergoing care, they can contact our utilization management team for a continuity of care request.

Services we provide you

ENROLLMENT

Sanford Health Plan offers multiple methods of enrollment, including:

Electronic enrollment

- **myEnrollment online portal**
Sanford Health Plan offers a secure, easy-to-use enrollment portal that supports health insurance enrollment as well as year-round enrollment transactions. If you already have an enrollment portal, you can use this site to review member eligibility or order replacement ID cards. Get access by visiting sanfordhealthplan.com/myenrollment.
- **Using an outside enrollment vendor**
Sanford Health Plan accepts ANSI X12N 834 benefit and enrollment maintenance transactions when submitted in compliance with our 834 companion guide (available online and by request). Contact your account executive or the client services department for this option.

It is your responsibility to notify your Client Services representative of changes to your HR team for access to myEnrollment.

Paper applications

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

Enrollment guidelines

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

New enrollments

New enrollments will occur from the following events:

- New hires electing coverage
- Existing employees electing coverage due to a qualified family status change (see qualified life events section on the following page)
- Existing employees electing coverage during annual open enrollment period

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

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

Qualified life events

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

Change in family status affecting a member such as:

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

Change in employment status affecting benefits such as:

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

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

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

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

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

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

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

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

NOTE: Members enrolled in a TRUE or PLUS product and move outside the service area will automatically be moved to the equivalent Signature Series (Broad Network) Plan.

Enrollment changes/terminations

Enrollment changes (including name or address changes, involuntary terminations or loss of eligibility, etc.) must be received at Sanford Health Plan within 31 days of the event.

- *my*Enrollment: enter all enrollment transactions through our online secure portal at sanfordhealthplan.com/myenrollment
- Enrollment change forms (if using paper) can be found within the Employer Resources page at sanfordhealthplan.org/employer-resources

Terminations—COBRA

If Sanford Health Plan is administering your COBRA, we will send COBRA election material, as required, within 14 days of receiving notification of a termination.

BILLING

Monthly premium invoices

Our standard billing practice allows coverage to begin the first of the month following the member's effective date and terminate on the last day of the month of employment. Monthly invoices are billed around the 20th of each month.

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

The premium billing invoice for the month of January may occasionally be delayed due to the processing of open enrollment changes.

COBRA administration

Sanford Health Plan provides complete COBRA administration services at no additional cost. COBRA is administered in-house. We provide initial COBRA notifications to new members, as well as election forms, unavailability notes, certificates of creditable coverage, premium rate computations, and other miscellaneous correspondence. The general notice is sent to all new members upon enrollment.

ONLINE SERVICE & SUPPORT

Employer resource page



This extensive resource page at sanfordhealthplan.com/employer-resources offers:

- Access to myEnrollment online enrollment portal
- Health & wellness information, including an electronic form to request wellness services
- Forms and more
- Toolkits and downloadables for the following topics:



Prevention



Cancer Screenings



Health Management



Healthy Habits



Sanford Health Plan Services

INFORMATION YOU NEED TO KNOW—WHEN YOU NEED IT

Sanford Health Plan is committed to keeping you informed of important subjects that affect your health insurance. You can expect to see email communication from us as frequently as monthly. Watch your email and the [employer resources page](#).

Be sure to inform your Account Executive of others in your organization who should be included on email communication, such as new HR representatives or members of your company’s wellness committee.

Access to care

HELP EMPLOYEES KNOW BEFORE THEY GO

Broad Network

Consists of over 25,000 providers within the Dakotas, Minnesota and Iowa. The network expands beyond the Sanford Health care system, including access to Multiplan's nationwide networks for urgent and emergent coverage while traveling or for members residing outside the Sanford Health Plan service area.

Focused Network

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

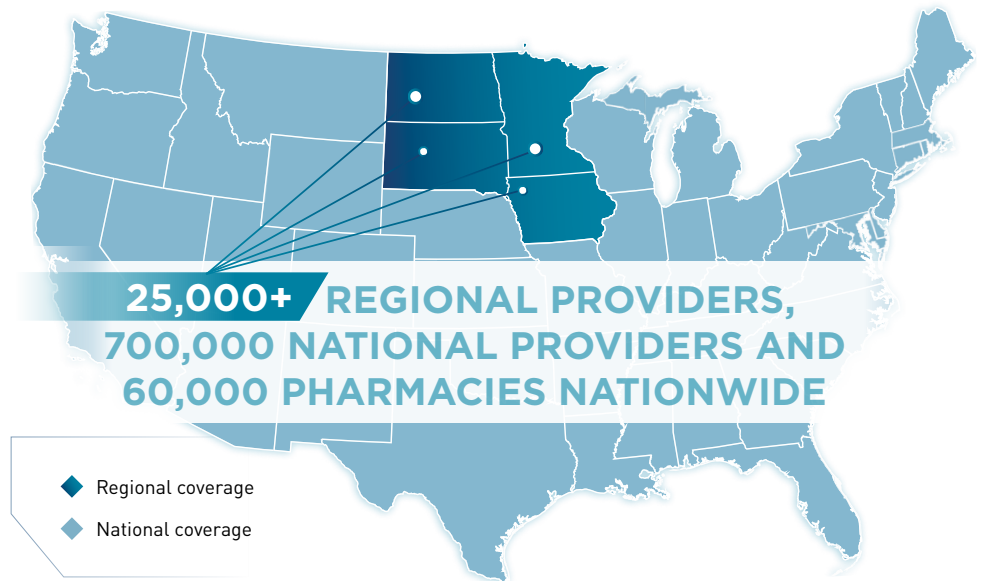
Tiered Network

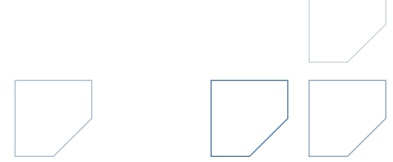
Sanford Health Plan's Broad network is grouped into two tiers. Member's cost share is based on the tier of the provider from whom they receive care. Tier 1 (lowest member cost-share) includes our large care system of Sanford Health providers and facilities. Tier 2 (higher member cost-share) includes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

Members can contact customer service or view our online provider directory at www3.viiad.com/shp/public if they have questions about providers within these networks.

NEW OR TERMINATED PROVIDERS

Our online provider directory is updated weekly with newly contracted providers. View this directory by visiting www3.viiad.com/shp/public. When a provider is terminated, Sanford Health Plan will send a letter to any member who saw the provider within the last 12 months. The letter will include alternate providers available to the member.





NOMINATING A PROVIDER

On occasion, there may be a member seeking services from a provider or facility currently not in the Sanford Health Plan network. In this event, the employee can complete a provider nomination form, located on the provider directory. Although we cannot guarantee the providers participation, we will contact the provider for participation in our network.

PROVIDERS OUTSIDE SERVICE AREA

Members who need services, which are considered urgent or emergent, can seek care at any provider regardless of the provider network selected. Members with non-emergency services that are referred to out-of-network providers will need prior approval (by calling Utilization Management) BEFORE they receive care (i.e. Mayo Clinic). The request is reviewed for appropriate medical necessity or continuity of care. Some plans do not offer out of network coverage, so members are encouraged to check their insurance information (i.e. SBC) before receiving services outside the network. A national network is available to those members living or residing outside the Sanford Health Plan service area.

PROVIDERS IN OTHER COUNTRIES

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

TRANSPLANT NETWORK

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



NO-COST AND LOW-COST OPTIONS

Sanford Health Plan is committed to helping our members maintain a healthy lifestyle. While most members don't think of utilizing their health insurance until they need care to treat an injury or illness, Sanford Health Plan members can take advantage of some benefits proactively and often with little to no-cost. You can help promote the benefits listed in this section with the toolkits available on the [Employers Resources](#) page.

- **Preventive care services and screenings:** Encourage your employees to bring the [Preventive Health Guidelines](#) to their appointment with the primary care physician to ensure the services performed are those covered at 100%.
- **Nutrition and exercise consults:** These free consults are delivered virtually or by phone to help employees create a diet and/or exercise plan specific to their needs.
- **Wellness Coaching:** This free six week one-on-one program is designed to help your employees reach lifestyle goals such as time management, stress management, meal planning, and more. Toolkits to promote these coaching sessions are available on the Employer Resources page or members can request services at sanfordhealthplan.com/members/wellness.

Well-being education

Our team of experts provide interactive and engaging trainings in all areas of health and well-being. These are available to you in person or through a live webinar.

Our offerings include:

- ✓ Body mechanics and posture
- ✓ Flourishing Financially
- ✓ Get Moving at Work
- ✓ Mindful Eating
- ✓ Overcoming Stress
- ✓ Quit Clinic
- ✓ Well-being for prevention
- ✓ Other targeted programs

To schedule an on-site presentation or live webinar, contact your Sanford Health Plan Account Executive or order from the Employer Resources page at sanfordhealthplan.com/employer-resources.

Fitness center reimbursement

This benefit includes a \$20 monthly (\$40 monthly maximum) reimbursement for the insured employee and insured spouse each month they use the gym 12 or more times. The gym must be a participating fitness facility in the NIHCA organization found at nihcarewards.org. This benefit is taxable. You will receive a report each year (November to October data) for the past 12 months of reimbursements.

Online wellness portal

Members have access to an online wellness tool, where they can complete a health assessment and select areas of interest. The site analyzes the member's health assessment results to generate a personalized health and well-being plan—while offering added online engagement tools and support.

Virtual care/telemedicine services

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

PRIOR AUTHORIZATION OR UTILIZATION REVIEW

What it is and what services need to be authorized

Medical utilization review

The Sanford Health Plan Utilization Department is available for both providers and members for the authorization of certain outpatient and inpatient services. Authorization is necessary to ensure our members receive the appropriate level of care and that the care is medically necessary. Providers are responsible for authorizing services for members. A complete list of services requiring authorization can be found within the secure member portal at sanfordhealthplan.com/memberlogin.

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

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

Pharmacy utilization review

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

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

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

Preventive drug benefit

Sanford Health Plan also offers a \$5 preventive drug benefit to our employers who offer an HSA Qualified High Deductible Health Plan to their employees. Members who are enrolled in the HSA Qualified High Deductible Health Plan are eligible for this benefit. Members can find the drug pricing tool at optumrx.com/oe_sanfordhealthplan/landing. For members who are enrolled in traditional copay plans, there are generic medications available for free if the retail cost is less than \$6. Members can visit with their providers for appropriate options within this benefit.

Claims administration

HOW WE PAY CLAIMS

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

AUTO ADJUDICATION

Sanford Health Plan processes approximately 94 percent of its claims electronically.

EXPLANATION OF BENEFITS (EOB)

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

Members are able to elect electronic EOBs (instead of EOB mailing) through their secure member account at sanfordhealthplan.com/memberlogin.

B Claim Number: 1234567									
D Provider/Vendor Name: DOCTOR NAME / FACILITY NAME/PLACE OF SERVICE									
A Date of Service	Medical Service Details		Member Benefit		Amount Provider May Bill You			L Notes*	
	C Type of Service	E Amount Billed	F Plan Discount	G Amount Paid by Plan	H Copay	I Deductible	J Coinsurance		K Amount Not Covered
XX/XX/XXXX - XX/XX/XXXX	<type of service>	\$XXXXX.XX	\$XXXXX.XX	\$XXXXX.XX	\$XX.XX	\$XXXXX.XX	\$XXXXX.XX	\$XXXXX.XX	<claim notes>
Claim Total:		\$XXXXX.XX	\$XXXXX.XX	\$XXXXX.XX	\$XX.XX	\$XXXXX.XX	\$XXXXX.XX	\$XXXXX.XX	
							Amount You May Owe		\$XXXXX.XX
L *Notes									
<claim notes>									

- A Date of Service:** The date(s) you received care.
- B Claim Number:** Reference number Sanford Health Plan assigned to the submitted claim.
- C Type of Service:** Type of medical service received.
- D Provider/Vendor Name:** The provider or facility you received the service from.
- E Amount Billed:** Amount the provider or facility billed for the service.
- F Plan Discount:** Amount saved by using an in-network or participating provider (if applicable). Sanford Health Plan negotiates lower rates with these providers to help save money.
- G Amount Paid by Plan:** The maximum amount Sanford Health Plan allows a provider or facility to charge for the service(s).
- H Copay:** A set amount you pay for certain services, such as an office visit.
- I Deductible:** The amount of covered expense that must be paid by the member before Sanford Health Plan begins to pay. For example, if your deductible is \$1,500, Sanford Health Plan won't pay for covered benefits until you've paid \$1,500 for services that are subject to the deductible, which may include labs, imaging, procedures and hospitalizations.
- J Coinsurance:** The percentage of the payment that you are responsible for, once the deductible has been met. Coinsurance amount is calculated on the amount paid by the plan. For example, if you have a \$100.00 service after you've met your deductible and your coinsurance is 80/20, the Plan will pay for 80 percent (\$80) and you will pay 20 percent (\$20).
- K Amount Not Covered:** Any amount that may not be covered by your benefit plan.
- L Notes:** Important information; these numbers and/or codes explain more about how claim was processed.



COORDINATION OF BENEFITS

When a member is covered by two health insurance plans, we must determine which plan pays first and which plan pays second, referred to as “Coordination of Benefits (COB)”. To ensure that our records are accurate and up to date, Sanford Health Plan may contact specific employees (with family coverage) to verify if other coverage exists. If your employees have received a COB request, please encourage them to complete the form to prevent claim payment delays. Questions about COB can be sent to healthplanCOB@sanfordhealth.org. Additional information can be found at sanfordhealthplan.com/employer-resources/forms-and-brochures.

SUBROGATION CLAIMS REVIEW—THIRD PARTY LIABILITY

It is important that we are good stewards of your health care premium dollars. Therefore, Sanford Health Plan partners with Optum to research certain claims that could be someone else’s responsibility; this is called subrogation. (For example, motor vehicle insurance may be responsible for medical costs from a car accident.) When we receive claims with certain diagnosis codes, Optum contacts the member to determine if another party was responsible for the charges. If your employee asks about a call or has received a form in the mail from Optum, please have the employee respond to the questions appropriately, as their claims may be denied. Communication from Optum will be identified as “working on behalf of Sanford Health Plan”. Members have three ways to provide the information to Optum: by phone, by mail, or online at icc.optum.com.

All information is strictly confidential and used only to determine payment liability.

HIGH-DOLLAR CLAIMS AUDIT

High dollar claims are flagged for manual review by claims examiners and audited before claim payment.

OUT-OF-AREA/OUT-OF-COUNTRY CLAIMS

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

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

PHYSICIAN ON STAFF FOR REVIEW OF CLAIMS

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

AUDIT PROGRAMS

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

APPEALS

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

Caring for your employees

CARE MANAGEMENT PROGRAMS

Sanford Health Plan offers the following services to our members:

- Consulting for options to improve health of group
- New case management model with focus on the highest risk engaged members including transplant, oncology, behavioral health, end stage renal disease, high risk pregnancy, NICU and complex medical conditions
- Team approach for holistic interventions (care for the whole person) with referrals to additional needed services like social work, medical, behavioral health, care management, pharmacy, community resources & wellness resources
- Integration with health system resources and appropriate referrals
- Employer reporting: enhanced actionable reporting on new program structure and impact/outcome to groups
- Engagement and collaboration with care team (including primary care provider) on member goals and plan of care

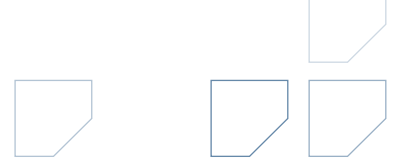
This team includes care managers that work closely with other health care staff and give the highest level of privacy for each member.

QUALITY IMPROVEMENT PROGRAM

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

WORKSITE PREVENTION AND SCREENINGS

Sanford Health Plan clients have several opportunities for bringing prevention and screening services to their worksite. After screening events are complete, Sanford Health Plan provides you with an aggregate report of your screening results and a strategy to improve the overall health of your organization. Sanford Health Plan offers various tools and other customized programming to implement in your workplace. You can request screenings for your workplace at [sanfordhealthplan.com/employer-resources](https://www.sanfordhealthplan.com/employer-resources).



Health and Well-being Screening

Sanford Health Plan's unique approach to evaluating organizational health goes beyond physical health. We evaluate overall employee health and well-being across six dimensions. When employees are thriving across all six dimensions of well-being, research tells us they are not only happier and more productive at work, but also experience up to 40 percent lower health care costs compared to employees who are only thriving in two dimensions or less. Knowing exactly what is holding your employees back is key to both employee health and organizational wealth.

The Health and Well-being Screening captures biometric indicators, in addition to the six dimensions. Biometrics include cholesterol, glucose and blood pressure to identify risk factors for disease. We deliver proactive recommendations for follow up and schedule appointments as needed for your employees.

As part of this comprehensive worksite screen, we make community intervention referrals, including fitness classes, chronic disease management classes and weight management resources; and promote sustainable healthy lifestyle habits through coaching. This screen can be conducted either onsite or virtually.

Well-being Screening

The Well-being Screening focuses on the Six Dimensions of Well-being: physical, career, social, emotional, financial and community. Many times we only focus on our physical health, and this can hold us back from feeling our best. All six dimensions are interconnected and contribute to our overall health, with career well-being as the primary driver of our wellness. Biometrics are not collected as part of this screening, and it can be conducted either onsite or virtually.

Diabetes Risk Screening

The Diabetes Risk Screening identifies risk for developing type 2 diabetes. One out of three US adults are pre-diabetic, but most do not know it. People with pre-diabetes have blood glucose (sugar) levels that are higher than normal. While levels are not yet high enough to be diagnosed with type 2 diabetes, people with pre-diabetes are likely to develop the disease within 10 years without intervention. This screen can be conducted either onsite or virtually.

Big Squeeze Blood Pressure Screening

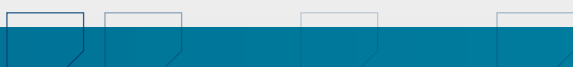
The Big Squeeze increases awareness of blood pressure and health risks associated with high blood pressure. High blood pressure is known as the "silent killer" because most people who have it do not have symptoms. Nearly half of US adults (103 million) have high blood pressure, and many don't know they have it. High blood pressure is the number one cause of stroke in the USA.

Flu shots

Sanford Health Plan can coordinate the delivery of flu shots at your worksite as part of your overall wellness program.

Employee prevention education

Having the knowledge of how to take the best care of yourself is important. Sanford Health Plan makes educating your employees easy by offering promotional materials on preventive care.





Ancillary Services

CONSUMER DIRECTED HEALTH PLANS

Sanford Health Plan offers a range of flexible benefit options to meet your needs. Our employer and employee funded plans give your business and employees tax-free options to pay for out-of-pocket medical and dependent care expenses. All our consumer directed health plans are administered by our partner, HealthEquity.

Flexible spending accounts

HealthEquity administers both medical and dependent care flexible spending accounts (FSA) and Limited FSA accounts (to partner with HSA accounts). These accounts provide a method to offer tax savings for both employers and employees allowing employees to pay for certain eligible expenses with pre-tax dollars. Debit cards are offered with these accounts, offering a convenient payment method for eligible medical FSA expenses. HealthEquity offers both 24/7 online access and mobile apps with these accounts at sanfordhealthplan.com/memberlogin.

Health reimbursement accounts

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

Health savings accounts

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

Reports

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

- ✓ Enrollment/demographics
- ✓ Claims dollars by expense distribution
- ✓ Claims by disease
- ✓ Top places of service and providers
- ✓ High cost claims by diagnosis category
- ✓ Medical and pharmacy PMPM (per member per month)
- ✓ Pharmacy utilization

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



Your responsibility

Sanford Health Plan is your partner in keeping your health insurance plan compliant. The following information provides you with required disclosures and notices that apply to group health plans subject to ERISA. Sanford Health Plan provides many of these notices to you and your employees. However, you, as an employer, may be required to deliver some items directly to your employees. For example, it is your responsibility to ensure each eligible employee receives the Summary of Benefits and Coverage (SBC) (ordered by your agent) prior to enrollment or during open enrollment. Take the time to become familiar with your responsibilities—indicated as shaded rows in the following table.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PLAN DOCUMENT AND FORMS

Summary of Benefits and Coverage (SBC)

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

Employees should also receive our Employee Decision Guides upon enrollment (or renewal) to help them make a decision about their health insurance options. Both of these documents can be ordered through your agent.

New member documents

Currently, when one of your employees enrolls in medical insurance with Sanford Health Plan, they receive the following separate mailings:

- ✓ ID card – 1 card for single coverage, 2 cards for all other coverages; mailed to the home address of the employee (all cards in the subscriber's name)
- ✓ Information on where to obtain the Summary of Benefits & Coverage (SBC), SBC for their specific plan, a Member Handbook, and a Certificate of Insurance (Policy)

Forms

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





PRIVACY & COMPLIANCE

HIPAA COMPLIANCE

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

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

CORPORATE COMPLIANCE PROGRAM

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

SECURITY

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

PROTECTING YOUR ENROLLMENT INFORMATION

To protect your enrollment information, please let us know when your Human Resources team changes. This is most important if you are using our *my*Enrollment portal.



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HEALTH PLAN