



**Amendment to Your
South Dakota Large & Small Group
Health Benefits Policy**

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This Amendment is effective February 1, 2008 and applies to your health Certificate of Coverage dated January 2006. Please review this document carefully and keep it with your Policy for future reference.

AMENDMENT #1

Entire document

All references to "Certificate of Coverage" is hereby deleted and replaced by "Policy."

All reference to "Health Services Department" is hereby deleted and replaced by "Utilization Management Department."

All reference to "Medical Management Quality Committee" is hereby deleted and replaced by "Physician Quality Committee."

AMENDMENT #2

Introduction: Member Rights

Provision #7 is hereby deleted and replaced by the following:

7. Members have the right to a candid discussion with the Practitioners and/or Providers responsible for coordinating appropriate or medically necessary treatment options for their conditions in a way that is understandable, regardless of cost or benefit coverage for those treatment options. Members also have the right to participate with Practitioners and/or Providers in decision making regarding their treatment plan.

AMENDMENT #3

Introduction: Service Area

The provision titled, *Service Area, for IOWA* is amended to include Ida County.

AMENDMENT #4

Section 1: Enrollment. Eligibility Requirements for Dependents.

The provision defining a dependent child is hereby deleted and replaced with the following:

Dependent Child - To be eligible for coverage, a Dependent Child must meet all the following requirements:

1. Be unmarried;
2. Receive more than half of his or her support from the Subscriber; and
3. Be one of the following:
 - a. age eighteen (18) or younger; or
 - b. age twenty-nine (29) or younger and enrolled in and attending an accredited college, university, or trade or secondary school on a full-time basis. For the purpose of the Plan, the school's definition of "full-time student" shall be used to determine if a Dependent is a full time student; or
 - c. incapable of self-sustaining employment and Dependent on her or his parents or other care Providers for lifetime care and supervision because of a disabling condition that was present when the child was age eighteen (18) (or twenty-nine (29), if a full-time student). If the Plan so requests, the Subscriber must provide proof of the child's disability within *thirty-one (31)* days of the Plan's request.

AMENDMENT #5

Section 1: Special Enrollment for Individuals Losing Other Coverage

This provision is hereby deleted and replaced with the following:

Special Enrollment Rights

Special enrollment rights apply when an individual becomes an Employee's Dependent through marriage, birth, adoption, or placement for adoption, and also when an Employee's Dependent loses health coverage. In order to special enroll an Eligible Employee's new Dependent, The Plan will require the Eligible Employee to be enrolled also. Special enrollment rights extend to all benefit packages available under The Plan. Special enrollees are not treated as Late Enrollees subject to the pre-existing waiting period.

Any Eligible Group Member or Eligible Dependent who was not previously enrolled in the Plan and has lost prior coverage shall be able to enroll in the Plan within *thirty (30)* days after the date of exhaustion of the previous coverage provided that the following conditions are met:

1. **Waived Coverage.** The Eligible Group Member or Eligible Dependent was covered under a Group health plan or had health insurance coverage at the time coverage was initially (upon date of hire) offered to the Eligible Group Member or Eligible Dependent; or, after subsequently enrolling in other coverage, the Eligible Employee had an opportunity to enroll during the open enrollment period or at the time of a special enrollment period, but again chose not to enroll; and the Eligible Group Member stated

in writing at such time that coverage under a Group health plan or health insurance coverage was the reason for declining enrollment (applicable only if the Group required such a statement at such time and provided the individual with notice of such requirement at such time).

2. **Exhausted COBRA.** The Eligible Group Member's or Eligible Dependent's previous coverage was under a COBRA or state continuation provision and the coverage under such provision was exhausted.
3. **Change in Employer Eligibility Rules or Employer Contributions.** The Participant's previous coverage was not under COBRA and either the coverage was terminated as a result of loss of eligibility for coverage, coverage was terminated for a class of similarly situated individuals, or employer contributions toward such coverage were terminated.
4. **A Move out of the Plan's Service Area.** The Participant's previous coverage was terminated because the Participant no longer resides, lives or works in the Plan's Service Area and the Plan does not provide coverage for that reason.
5. **Cessation of Dependent status.** The Participant attains an age in excess of the maximum age for coverage of a Dependent Child.
6. **Reaching the Lifetime Maximum.** The Eligible Employee or Eligible Dependent's coverage was exhausted by reaching a lifetime limit on all benefits.

Requests for Special Enrollment must be received by The Plan not later than *thirty (30)* days after the date of exhaustion or termination of coverage.

AMENDMENT #6	Section 2. How you get care. Identification Cards.
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*The first paragraph in the provision for **Identification Cards** is hereby deleted and replaced with the following:*

The Plan will send you an identification (ID) card when you enroll. You must show it whenever you receive services from a Provider, a healthcare facility, or fill a prescription at a Plan pharmacy. If you fail to show your ID card at the time you receive healthcare services or prescription drugs, you will be responsible for payment of the claim after the Participating Practitioner's and/or Provider's timely filing period of one-hundred-twenty (120) days has expired. Your coverage will be terminated if you use your ID card fraudulently or allow another individual to use your ID card to obtain services.

AMENDMENT #7	Section 2. How you get care. Preconditions for Coverage.
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*The third paragraph provision regarding **Emergency and Urgent Care Situations** is hereby deleted and replaced with the following:*

If during an Emergency care or urgent care situation, the Member is in the Service Area and is alert, oriented and able to communicate (as documented in medical records); the Member must direct the ambulance to the nearest Participating Provider.

AMENDMENT #8	Section 2. How you get care. Utilization Review Process.
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The following provision revises the description of how to access the Utilization Review department by adding the Plan's fax number.

The Plan's Utilization Management Department is available between the hours of 8:00am and 5:00pm Central Time, Monday through Friday, by calling the Plan's toll-free number 1-800-805-7938 or (605) 328-6807. After hours you may leave a message on the confidential voice mail of the Utilization Management Department and someone will return your call. You can also fax the Plan at (605) 328-6813.

AMENDMENT #9	Section 2. How you get care. Utilization Review Process.
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*The following provision is added as the fifth paragraph to the section on **Prospective (pre-service) Review of Services (Certification/Prior Authorization)**:*

Admission before the day of non-emergency surgery will not be authorized unless the early admission is medically necessary and specifically approved by the Plan. Coverage for hospital expenses prior to the day of surgery will be denied unless authorized prior to being incurred.

AMENDMENT #10	Section 2. How you get care. Services that Require Prospective Review/Prior Authorization (Certification)
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This provision is added to the list of services that require prior authorization:

- Intensive Outpatient Programs for substance abuse treatment

The provision on Referrals is hereby deleted and replaced by the following:

9. **Referrals to Non-Participating Providers which are recommended by Participating Providers.** Certification is required for the purposes of receiving In-Network coverage only. If Certification is not obtained for referrals to Non-Participating Providers, the services will be covered at the Reduced Payment Level. Certification does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers as described in Section 2.

AMENDMENT #11	Section 2. How you get care. Prospective Review Process (Non-urgent Pre-service) for Elective Inpatient Hospitalizations, Non-Urgent Medical and Behavioral Health Care, Pharmaceutical and Benefit Requests
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The third paragraph provision regarding obtaining authorization (Certification) for services is hereby deleted and replaced with the following:

You are ultimately responsible for obtaining authorization (Certification) from the Utilization Management Department. Failure to obtain Certification will result in coverage at the Reduced Payment Level.

AMENDMENT #12	Section 2. How you get care. Prospective Review Process (Non-urgent Pre-service) for Elective Inpatient Hospitalizations, Non-Urgent Medical and Behavioral Health Care, Pharmaceutical and Benefit Requests
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*The third paragraph provision in the section titled **Concurrent Review Process for Medical and Behavioral Health Care Requests**, is hereby deleted and replaced with the following:*

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 Determination. 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 make an urgent concurrent determination and notify the Member, or the Member’s Authorized Representative, Practitioner and those Providers involved in the provision of the service by telephone 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.

AMENDMENT #13	Section 2. How you get care. Prospective Review Process (Non-urgent Pre-service) for Elective Inpatient Hospitalizations, Non-Urgent Medical and Behavioral Health Care, Pharmaceutical and Benefit Requests
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*The title of the 5th paragraph provision in the section titled **Concurrent Review Process for Medical and Behavioral Health Care Requests**, is changed to:*

Urgent Concurrent Reviews Requested After Twenty-Four (24) Hours Prior to Expiration of Authorization

AMENDMENT #14	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers
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This provision describing preventive care that is covered for adults is hereby deleted and replaced with the following:

**Preventive care, adult
FOR MEN ONLY**

Prostate Screening

- One prostate cancer screening including PSA every year:
 - Ages 50 and older; or
 - Ages 40 and older who are symptomatic or in a high risk category

AMENDMENT #15	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers
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These provisions describing preventive care that is covered for children are hereby deleted and replaced with the following:

Preventive care, children

Pediatric Preventive visits including periodic examinations and laboratory testing, as outlined in the Plan Preventive Health Guidelines. For children through age six (6) years old, benefits shall be provided at the following age intervals: 2 weeks, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, 3 years, 4 years, 5 years and 6 years.

Routine Immunizations

Medically accepted methods of prophylaxis which prevent disease

AMENDMENT #16	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers
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These provisions describing covered maternity benefits are hereby deleted and replaced with the following:

Maternity Care

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

Maternity care includes prenatal through postnatal maternity care and delivery and care for complication of pregnancy of mother. We cover up to two (2) routine ultrasounds per pregnancy to determine fetal age, size, and development.

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 and/or Provider, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If such an inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by Participating Practitioners and/or Providers competent in postpartum care and newborn assessments.

NOTE: We encourage you to participate in our Healthy Pregnancy Program; Call 1-800-805-7938 to enroll.

AMENDMENT #17	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers
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These provisions describing covered and non-covered family planning benefits are hereby deleted and replaced with the following:

Covered Family Planning Benefits

- Family Planning Services include consultations, and pre-pregnancy planning
- There is no coverage for oral contraception unless required by State law and/or covered by a supplemental prescription drug rider as purchased by your Employer (Note: See the prescription drug benefit in Section 3(e))
- Voluntary Sterilizations include tubal ligations and vasectomies
- Mirena IUD device is covered up to \$350 every five (5) years

Not covered:

- genetic counseling or testing
- reproductive Health Care Services prohibited by the laws of This State
- elective abortion services
- birth control drugs and devices including but not limited to the Implanon and implantable contraceptive device
- diaphragms, condoms, foam or sponges
- sterilization of Dependent children
- reversal of voluntary sterilization

AMENDMENT #18	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers
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This provision is removed from list of diabetic services and supplies that are not covered and is now a covered service:

Diabetes supplies, equipment, and education

- dialysis services received by non-Participating Providers when traveling out of the Service Area

This provision is added to the list of diabetic services and supplies that are not covered:

Not covered: continuous glucose monitoring system

AMENDMENT #19	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers
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This provision is added to the list of services that are not covered:

Physical, cardiac, speech and occupational therapies

- Speech therapy for the purpose of correcting speech impediments (stuttering or lisps), or assisting the initial development of verbal facility or clarity; voice training and voice therapy.

AMENDMENT #20	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers
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The following DME has been removed from the list of equipment that requires Certification/prior authorization:

Durable Medical Equipment (DME)

- oxygen concentrators

AMENDMENT #21	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers
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These provisions describing covered tobacco cessation benefits are hereby deleted and replaced with the following:

Tobacco/Smoking Cessation Treatment

Non-drug tobacco treatment covered up to \$100.00 and limited to once per lifetime for the therapy of the Member's choice from the following:

- physician counseling and treatment;
- smoking cessation classes; and
- visit to a Certified Respiratory Therapist.

The following smoking deterrent medications will be covered with confirmation of smoking abstinence after a 6-month period: nicotine patches, gum, nasal spray, Chantix, Zyban or Wellbutrin.

AMENDMENT #22	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers
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This provision describing non-coverage for surgeries to correct congenital deformities is clarified to read:

Reconstructive Surgery

Not covered: Surgeries to correct congenital deformities unless treatment was started before the age of eight (8).

AMENDMENT #23	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers
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The following provision applies to the covered section and deletes the requirement that members be covered under the Health Plan during the time of illness or injury to the teeth in order for oral surgical procedures to be covered and adds coverage as follows:

Oral and maxillofacial surgery

Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth Orthognathic Surgery per Plan guidelines

The following provision is added to the non-covered section:

Not covered: Extraction of Wisdom teeth

AMENDMENT #24	Section 3(a) Medical services and supplies provided by healthcare Practitioners and Providers
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These provisions describing covered transplant benefits are hereby deleted and replaced with the following:

Transplants

NOTE: Certification is required; failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 2.)

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

Solid organ transplants are limited to:

- Cornea
- Heart
- Heart/lung
- Kidney

- Kidney/pancreas
- Liver
- Intestinal transplants
 - Small intestine
 - Small intestine with the liver
 - Small intestine with multiple organs, such as the liver, stomach, and pancreas
- Lung: single, double
- Pancreas

Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description.)

- Allogenic transplants for:
 - Acute or chronic lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia
 - Burkitt's lymphoma for adolescents and young adults
 - Advanced Hodgkin's lymphoma
 - Advanced non-Hodgkin's lymphoma
 - Chronic myelogenous leukemia
 - Severe combined immunodeficiency
 - Severe or very severe aplastic anemia
- Autologous transplant for:
 - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia
 - Advanced Hodgkin's lymphoma
 - Advanced non-Hodgkin's lymphoma
 - Advanced neuroblastoma
 - Autologous tandem transplants for recurrent germ cell tumors (including testicular cancer)
- Blood or marrow stem cell transplants for:
 - Allogenic transplants for
 - Phagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome)
 - Advanced forms of myelodysplastic syndromes
 - Sickle cell anemia

Blood or marrow stem cell transplants are covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan's medical director in accordance with the Plan's protocols for:

- Allogenic transplants for:
 - Multiple myeloma
- Nonmyeloablative allogenic transplants for:
 - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia
 - Advanced forms of myelodysplastic syndromes
 - Advanced Hodgkin's lymphoma
 - Advanced non-Hodgkin's lymphoma
 - Chronic myelogenous leukemia
- Autologous transplants for:
 - Chronic myelogenous leukemia
 - National Transplant Program

All transplants must be provided at Plan participating Center of Excellence facilities

Prescribed post-transplant immunosuppressant outpatient drugs required as a result of a covered transplant

Coverage includes up to \$25,000 for acquisition fees

Medical expenses for the organ donor which are necessary for the transplant, and which are not covered by another Group health plan or other coverage arrangement

Not covered:

- Transplant evaluations with no end organ complications
- Harvesting and storage of stem cells
- 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 and these services are not covered under another Group health plan or coverage arrangement
- Costs related to locating and/or screening organ donors
- 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 medical director or its designee
- Services, chemotherapy, supplies, drugs and aftercare for or related to transplants performed at a non-Plan Participating Center of Excellence
- Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria

AMENDMENT #25	Section 3(c) Emergency services/accidents
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The definition of an "urgent care situation" is hereby deleted and replaced with the following:

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. Urgent care 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:

- 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
- In the opinion of a Practitioner and/or 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.

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 urgent care or after hour's clinic.

The Health Plan covers worldwide emergency services necessary to screen and stabilize Members without Certification in cases where a Prudent Layperson, acting reasonable, believed that an Emergency Medical Condition existed.

AMENDMENT #26	Section 3(c) Emergency services/accidents
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The third paragraph provision regarding emergencies that occur within the service area is revised by adding the following statement:

Emergency within our service area

The Health Plan covers emergency services necessary to screen and stabilize members without pre-certification in cases where a prudent layperson, acting reasonably, believed that an emergency medical condition existed.

AMENDMENT #27	Section 3(d) Mental health and substance abuse benefits
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The following provision is added after the second paragraph to the covered benefits section for mental health benefits:

Mental health benefits (biologically-based)

If you are having difficulty obtaining an appointment with a mental health practitioner and/or Provider or for behavioral health needs assessment services by phone, call the Sanford USD Medical Center Triage Line at (605) 328-4777 or toll free at (888) 996-4673.

This provision is added to the list of mental health services that are covered:

Partial Hospital Programs and Day Treatments

These provisions describing covered addiction and substance abuse benefits are hereby deleted and replaced with the following:

Addiction and substance abuse benefits

Addiction substance abuse services includes Alcohol, Chemical, and Gambling Treatment

Outpatient coverage is limited to *thirty (30)* days' care in any consecutive six-month period

Intensive Outpatient Programs and Partial Hospital Program/Day Treatment

Every *two (2)* days of Intensive Outpatient Programs and Partial Hospital Program (PHP)/Day Treatment counts towards *one (1)* day of inpatient services and is applied toward the inpatient limit

NOTE: Certification is required for these benefits; failure to get Certification will result in a reduction or denial of benefits.
(See Services requiring Certification in Section 2.):

Inpatient services provided by a Hospital or other Facility and services in approved alternative care settings such as Intensive Outpatient Programs, Partial Hospital Programs/Day Treatment

Inpatient coverage is limited to *thirty (30)* days in any consecutive six-month period with a *ninety (90)* day lifetime maximum for inpatient treatment at any Participating treatment Facility.

AMENDMENT #28	Section 3(e) Prescription drug benefits
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These provisions revises the following non-covered benefits:

Not covered:

- Acne medication for Members over age thirty (30)
- Birth control drugs and devices including but not limited the Implanon and other implantable contraceptive devices

AMENDMENT #29	Section 3(f) Dental benefits
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The following provision applies to the covered section and deletes the requirement that members be covered under the Health Plan during the time of illness or injury to the teeth in order for oral surgical procedures to be covered and adds coverage as follows:

Dental benefits

Oral surgical procedures limited to services required because of injury, accident or cancer that damages Natural Teeth

The following provision is added to the non-covered section:

Not covered: Extraction of Wisdom teeth

AMENDMENT #30	Section 4. Limited and Non-Covered Services
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This provision hereby deletes and replaces exclusion #26:

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.

26. Any services or supplies for the treatment of obesity, including but not limited to: dietary regimen (except as related to covered nutritional counseling) and surgical treatment for reducing or controlling weight; bariatric treatment centers; medical care or prescription drugs; nutritional supplements (services supplies and/or nutritional sustenance products or food related to enteral feeding except when it's the sole means of nutrition); food supplements; any services or supplies that involve weight reduction as the main method of treatment, including medical or psychiatric care our counseling; weight loss or exercise programs; nutritional supplements; appetite suppressants and supplies of a similar nature; and products including but not limited to liposuction, gastric balloons, jejunal bypasses and wiring of the jaw

These provisions are added as non-covered services:

- Inpatient or residential treatment of bulimia, anorexia or other eating disorders\
- Genetic testing

AMENDMENT #31	Section 5. How services are paid for by the Plan
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This provision revises the first paragraph to clarify that Members must present their ID cards when receiving healthcare services:

Reimbursement of Charges by Participating Providers

When you see Participating Providers, receive services at Participating Providers and facilities, or obtain your prescription drugs at Network pharmacies, you will not have to file claims. You must present your current identification card and pay your Copay.

This provision revises the first paragraph to clarify that Members may need to file their own claims when receiving healthcare services from Non-Participating Providers:

Reimbursement of Charges by Non-Participating Providers

You may need to file a claim when you receive services from Non-Participating Practitioner and/or Providers. Sometimes these Practitioners and/or Providers submit a claim to us directly.

AMENDMENT #32	Section 6. Problem Resolution
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The first paragraph of this provision is revised by adding the following statement:

MEMBER GRIEVANCE PROCEDURES

The Member or 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 request.

The definition of an “urgent care request” is hereby deleted and replaced with the following:

Definitions

Urgent care situation: A degree of illness or injury which is less severe than an Emergency Condition, but requires prompt medical attention within twenty-four (24) hours. Urgent care requests means a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care Request determination could:

- a. 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 judgement; or
- b. In the opinion of a Practitioner and/or 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.

AMENDMENT #33	Section 6. Problem Resolution
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*This provision under the section titled, **Types of Grievances (Appeals), Filing Deadline**, is revised to clarify that Authorized Member Representatives must be designated in writing by the Member.*

Within one hundred eighty (180) days after the date of receipt of a notice of an Adverse 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 a Grievance with the Plan requesting a first level review of the Adverse Determination.

*This provision under the section titled, **1st Level Standard Review Procedure for Complaints (Grievances NOT involving Adverse Determination)**, is revised to clarify that Authorized Member Representatives must be designated in writing by the Member.*

A standard appeal may be requested by a Member, his or her representative (as designated in writing) or Practitioner and/or Provider by writing or telephoning the Member Services Department at 1-800-752-5863 or (605) 328-6800. The Grievance process is included in the Member’s initial determination letter.

*This provision under the section titled, **Grievance Procedure involving Adverse Determinations**, is revised to clarify that Authorized Member Representatives must be designated in writing by the Member.*

If the Member or a Member’s authorized representative (as designated in writing) files a Grievance for an Adverse Determination, Members do not have the right to attend or have a representative attend the first level review, but Members are entitled to:

1. Send written comments, documents, records and other material relating to the request; and
2. Receive reasonable access to documents, records and other information relevant to the request, free of charge.

The attending Practitioner and/or Provider and the Member will be made aware of their responsibility for submitting the documentation required for resolution of the Grievance within three (3) working days of receipt of the Grievance.

AMENDMENT #34	Section 6. Problem Resolution
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*Provision #3 under the section titled, **Independent, External Review of Final Determinations**, is revised by adding the following statements:*

Independent, External Review of Final Determinations

3. Conduct of the appeal program as follows:
 - iv. Engages adequate numbers of actively participating practitioners with the appropriate level and type of clinical knowledge and experience to adjudicate appeals;
 - v. Bases its review on sound clinical evidence, referencing peer-review literature, medical technology assessments and the individual patient record;
 - vi. Carefully protects member identify, medical record and case information from any unnecessary disclosure; and
 - vii. Have effective systems in place to manage the many administrative aspects of appeals, such as tracking cases and accessing legal and medical documents. Provides staff with education and skills training that is required to produce sound, high-quality results.

AMENDMENT #35	Section 7. Coordination of Benefits
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Provision #1 under the section “Order of Benefit Determination Rules” is hereby deleted and replaced by the following:

1. **General.** When two or more plans pay benefits, the rules for determining the order of payment is as follows:
 - a. The primary plan pays or provides benefits as if the secondary plan or plans did not exist.
 - b. If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall pay or provide benefits as if it were the primary plan when a covered person uses a nonpanel provider, except for emergency services or authorized referrals that are paid or provided by the primary plan;
 - c. If multiple contracts providing coordinated coverage are treated as a single plan under South Dakota State law §§ 58-18A-53 to 58-18A-83, inclusive, this section applies only to the plan as a whole, and coordination among the component contracts is governed by the terms of the contracts. If more than one carrier pays or provides benefits under the plan, the carrier designated as primary within the plan shall be responsible for the plan's compliance with this law;
 - d. If a person is covered by more than one secondary plan, this order of benefit determination provisions decide the order in which secondary plans benefits are determined in relation to each other. Each secondary plan shall take into consideration the benefits of any primary plan and the benefits of any other plan, which has its benefits determined before those of that secondary plan;
 - e. Except as provided in subdivision (b) of this section, a plan that does not contain order of benefit determination provisions that are consistent with South Dakota State law §§ 58-18A-53 to 58-18A-83, inclusive, is always the primary plan unless the provisions of both plans, regardless of the provisions of this section, state that the complying plan is primary;
 - f. Coverage that is obtained by virtue of membership in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

AMENDMENT #36 | Section 8. Definitions

The following definitions are hereby deleted and replaced with the following:

Coinsurance	The percentage of charges to be paid by a Member for Covered Services after the Deductible has been met.
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 inpatient care, residential behavioral care, intensive outpatient behavioral care and ongoing ambulatory care.
Out-of-Network Benefit Level	The lower level of benefits provided by The Plan, as defined in the attached Summary of Plan Benefits, when a Member seeks services from a Non-Participating Provider.
Partial Hospitalization Program	Also known as day treatment or partial hospitalization programs for mental health and Chemical Dependency Services mean a group-oriented treatment setting based on an intermediate level of care usually held during the daytime hours generally providing twenty (20) or more hours of therapeutic activities per week.

The term is added to the definitions section:

Reduced Payment Level	The lower level of benefits provided by The Plan, as defined in the attached Summary of Plan Benefits, when a Member seeks services from a Participating or Non-Participating Provider without Plan certification or prior-authorization when certification/prior-authorization is required.
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AMENDMENT #37 | Section 10. Options After Coverage is Ended

The third paragraph under the COBRA Section #1 is revised as follows:

Federal Continuation of Coverage Provisions (“COBRA”) for employer groups with *twenty (20)* or more employees.

1. What is Continuation Coverage?

It is the Member’s responsibility to notify Sanford Health Plan or their employer of a divorce, legal separation, or a child ceasing to be a dependent under the terms of the Plan within sixty (60) days of the date of the event.

All other terms and provisions of your benefits policy, including any amendments we may have previously issued, remain unaltered and in effect.