Individual Medicare Supplement Policy
Sanford SELECT
Basic Plan

Notice to buyer

The Commissioner of Commerce, State of Minnesota has established two options of *Medicare* SELECT supplements and minimum standards for each. The two options are the Extended Basic *Medicare* SELECT (the most comprehensive) and the Basic *Medicare* SELECT (the least comprehensive). This Policy describes your coverage under the Sanford Health Plan Basic *Medicare* SELECT option, called "Sanford SELECT" Basic.

THIS POLICY IS A LEGAL CONTRACT BETWEEN YOU AND SANFORD HEALTH PLAN. IT IS VERY IMPORTANT THAT YOU READ THIS ENTIRE POLICY VERY CAREFULLY. THIS POLICY MAY NOT COVER ALL OF YOUR MEDICAL EXPENSES.

This Policy does not provide coverage for prescription drugs except as required by *Medicare. Prescription drugs* can be a very high percentage of your medical expenses. Coverage for *prescription drugs* may be available to you. Please ask Sanford Health Plan for further details.

30 DAY RIGHT TO CANCEL

If after review, you are not satisfied with the coverage described in this Policy for any reason, you may cancel it by midnight of the 30th day after you receive it. To do so, you must return the Policy and give Sanford Health Plan written notice of cancellation by mail, delivery or facsimile. Mail must be postmarked by midnight of the 30th day, properly addressed to Sanford Health Plan and postage prepaid. Sanford Health Plan will return your *premium* within 10 days after receipt of the returned Policy and cancellation notice. You are responsible for repaying Sanford Health Plan or the *Sanford SELECT contracted providers* for any *claims* paid or services rendered during the 30 days.

Sanford Health Plan *Medicare* SELECT supplements your *Medicare* coverage. To determine which health services are covered by *Medicare*, you may request a *Medicare* handbook by contacting your local Social Security office.

RENEWAL AGREEMENT - GUARANTEED RENEWABLE SUBJECT TO PREMIUM CHANGE

Sanford Health Plan guarantees to renew this Policy as long as the *premium* is paid (on or before the due date or within the grace period) and you have not knowingly provided materially false information or misrepresentation on your application. Sanford Health Plan has the right to change the *premium* as stated in the following Section titled *Premium and Coverage Changes.*

This Policy will not be cancelled or non-renewed merely because your health deteriorates. If this particular Policy is no longer marketed, you will have the opportunity to purchase replacement coverage without pre-existing limitations or interruption of coverage.

NETWORK RESTRICTIONS

For the supplemental coverage under Sanford SELECT to apply, inpatient hospitalization services our outpatient surgery services described in this Policy must be received from *Sanford SELECT contracted providers* (hospital and outpatient surgery centers) who are part of the Sanford SELECT network.

You may go to *non-contracted* facilities to receive inpatient hospitalization or outpatient surgery services, but no coverage for facility expenses will be provided under this Policy, unless health services meet Sanford Health Plan's and/or *Medicare's* definition of an *emergency.*

Sanford SELECT supplemental coverage applies to services provided in the physician's office, in another office setting, or a skilled nursing facility. There are no network restrictions on benefits for services received in a non-hospital or non-outpatient surgery center setting beyond standard limitations of this policy.

This Policy replaces any Policy Sanford Health Plan previously issued to you, and will in turn be replaced by any subsequent Policy Sanford Health Plan issues to you in the future.

PREMIUM AND COVERAGE CHANGES

The premium cannot be changed unless any applicable regulatory approval has been obtained by Sanford Health Plan, and Sanford Health Plan makes the same change on all policies of this form that are in force at the time the premium is changed. Any such change can be made on any renewal date. See the Section titled *Paying Your Premiums* for further detail.

Automatic Change In Coverage: *Benefits* under this Policy that are designed to cover cost-sharing amounts under *Medicare* will be changed automatically to coincide with any changes in the applicable *Medicare deductible* and *coinsurance* percentage factors. Premiums may also be modified to correspond with these changes. Sanford Health Plan will notify you of any such changes no later than 30 days prior to the annual effective date of any Medicare benefit changes.

Suspension of Premiums and Coverage upon Medicaid Enrollment: Your coverage under this Policy and the premiums for it will be suspended at your request, for a period not to exceed 24 months, if you become enrolled in the Medicaid program. If you decide to suspend coverage under this Policy, you must notify Sanford Health Plan in writing within 90 days of your enrollment in Medicaid for suspension of this Policy to occur.

Upon receipt of notice, we will return that portion of the premium for the period of time you are enrolled in Medicaid. Your refunded premiums will be reduced by the amount of the services rendered or claims paid for the period you are eligible.

Coverage under this Policy may be reinstated when your Medicaid coverage ends; however, you must notify Sanford Health Plan of your decision to reinstate this Policy within 90 days of the

termination of Medicaid coverage. Your notice and payment of the required premium will reinstate your coverage under this Policy as follows:

1. there will not be an additional *waiting period for pre-existing conditions;*
2. the coverage will be substantially equivalent to what it was before the date of suspension; and
3. your premium class will be as favorable to you as it would have been if the coverage had not been suspended.

Suspension of Premiums and Coverage upon Enrollment in Group Health Plan: You may request a suspension in coverage if you are under age 65, enrolled in *Medicare* benefits as the result of disability, and enrolled in a group health plan sponsored by you current or former employer or employee organization. To suspend your policy, you must notify us within 90 days after the date you become enrolled in such group coverage. We shall return to you that portion of the premium paid by you which is attributable to the period of the other coverage, subject to adjustment for paid claims.

If a suspension occurs and you lose entitlement to the group coverage, your *Medicare* supplement policy will be reinstated automatically as of the date your group coverage is terminated if you notify us that you lost your group coverage. You must notify us within 90 days after the date of such loss. Your notice and payment of the required premium will reinstate your coverage under this Policy as follows:

1. there will not be an additional *waiting period for pre-existing conditions;*
2. the coverage will be substantially equivalent to what it was before the date of suspension; and
3. your premium class will be as favorable to you as it would have been if the coverage had not been suspended.

LOSS RATIO DISCLOSURE

NOTICE: This disclosure is required by Minnesota law. This policy is expected to return on average 75.6% of your premium dollar for health care. The lowest percentage permitted by state law for this policy of certificate is 65%.

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Important Consumer Information

Benefits:	Health services will be covered by Sanford Health Plan only if such services are provided by *Sanford SELECT contracted providers* or authorized by Sanford Health Plan. This Policy describes the health services for which you have coverage and the procedures you must follow to obtain *benefits.*
Providers:	Enrolling in Sanford SELECT does not guarantee that a particular hospital or outpatient surgery center on the list of *providers* will remain a *Sanford SELECT contracted provider* or that a particular *provider* will provide you with health services. Before each time you receive health services, ask the hospital or outpatient surgery center for verification as a *Sanford Health SELECT contracted provider* or call Sanford Health Plan for verification. When a *provider* no longer participates with Sanford SELECT, you must choose to receive your health services from among the remaining *Sanford SELECT contracted providers.*
Emergency Care:	*Emergency* services from *non-contracted providers* will be covered only if the services you require meet the definition of *emergency.*
Exclusions:	Certain health services are not covered. Read this Policy for a detailed explanation of all exclusions.
Cancellation:	You may cancel your coverage at any time (see the Section titled Ending Your Coverage). Sanford Health Plan may cancel your coverage only under certain conditions. This Policy describes all reasons for cancellation of coverage.
Mental Health and Substance Abuse:	All inpatient mental health and substance abuse services, except *emergency* services, must be received from *contracted providers* to be eligible for coverage.
Prescription Drugs and Medical Equipment:	Enrolling in Sanford SELECT does not guarantee that any particular prescription drug will be covered nor that any particular piece of medical equipment will be covered, even if the drug or equipment is covered at the start of the Policy year.

Member Bill of Rights

The laws of the State of Minnesota grant *members* of health maintenance organizations certain legal rights including the right to:

1. Available and accessible services, including *emergency* services (defined in this Policy), 24 hours a day, 7 days a week.

2. Information about your health condition, treatment options and risks so you can make an informed choice about your health care.

3. Refuse treatment recommended to you by Sanford Health Plan or any *provider.*

4. Privacy of your medical and financial records maintained by Sanford Health Plan or any *Sanford SELECT contracted provider* in accordance with existing law.

5. File a complaint with Sanford Health Plan (see the Section titled If You Have A Complaint) or Minnesota's Commissioner of Commerce. You may begin a legal proceeding if you have a problem with Sanford Health Plan or any *Sanford SELECT contracted provider.* For information, contact the Minnesota Department of Commerce ("DOC") at (651) 296-2488 or 1-800-657-3602.

6. You have the right to a grace period of 31 days to pay premiums due after your first payment. This Policy shall continue in force during the grace period.

7. You have the right to disenroll voluntarily from Sanford SELECT and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law.

8. You have the right to a clear description of nursing home and home care benefits covered under this Policy.

9. Be treated with respect and recognition of your dignity and right to privacy.

10. Receive information about Sanford Health Plan, its services, its practitioners and providers and *member* rights and responsibilities.

11. A candid discussion of appropriate or *medically necessary* treatment options for your condition regardless of cost or *benefit coverage* and to participate in the decision making regarding your health coverage.

Member Responsibilities

To increase the likelihood of maintaining good health and to ensure that the best quality care is received, it is important that you take an active role in your health care by:

1. Establishing a relationship with a *Sanford SELECT contracted provider* before becoming ill, as this allows for continuity of care;

2. Providing the necessary information to health care professionals that is needed to determine the appropriate care. This objective is best obtained when you:

   a. share information about lifestyle practices; and

   b. share personal and family health history;

3. Following the instructions given by those providing health care;

4. Practicing self care by:

   a. knowing how to recognize common health problems;

   b. knowing what to do when they occur;

   c. knowing when and where to seek appropriate help; and

   d. knowing how to prevent health problems from recurring;

5. Practicing preventive health care by:

   a. having the appropriate tests, exams, and immunizations recommended for your gender and age as described in this Policy; and

   b. engaging in healthy lifestyle choices (exercise, proper diet and rest, etc.). You will find additional information on Sanford Health Plan *member* responsibilities in the Section titled Introduction.

Non-Discrimination Policy

It is the policy of Sanford Health Plan to treat all persons alike, without distinctions based on race, color, creed, religion, national origin, gender, marital status, status with regard to public assistance, disability, sexual orientation, age or any other classification protected by law. If you have questions about this policy, contact Sanford Health Plan at one of the telephone numbers listed below. If you have an impairment that requires alternative communication formats such as Braille, large print or audiocassettes, please request these materials from Sanford Health Plan by calling one of the telephone numbers listed below. If one of these alternative communication formats is used, this written English version (not the alternative format) governs all coverage decisions.

Sanford Health Plan
Member Service
(605) 328-6800 or 1-800-752-5863
For hearing impaired *members:* TTY (605) 328-6869

A. Introduction

As a person enrolled in Sanford SELECT, you are issued this Policy, which describes the *benefits* you are entitled to receive. The *benefits* are subject to certain terms and conditions that are stated in this Policy and are available only if they are provided or authorized by a *Sanford SELECT contracted provider* or authorized by Sanford Health Plan. This Policy fully describes the health services for which you have coverage and the procedures you must follow to obtain coverage.

This Policy is designed as a supplement to traditional *Medicare* coverage. Basically, this Policy covers the *Medicare deductible, coinsurance* and other eligible out-of-pocket expenses when service is:

1. provided by a *Sanford SELECT contracted provider, and*

2. determined by *Medicare* to be eligible for coverage.

It also provides coverage for *benefits* mandated by the state of Minnesota. Sanford Health Plan may authorize more efficient methods of providing services that may be in addition to the *benefits* described in this Policy. Sanford Health Plan may arrange for various persons or entities to provide administrative services on their behalf, including coordination of benefit services. You must cooperate with those persons or entities in the performance of their responsibilities in order to ensure efficient administration of your *benefits.*

To be eligible to enroll for coverage under this Policy you must meet the criteria described in the Section titled Enrollment. Enrolling in Sanford SELECT does not guarantee that a particular hospital or outpatient surgery center on the list of *providers will* remain a *Sanford SELECT contracted provider* or that a particular *Sanford SELECT contracted provider* will provide you with health services. Before receiving hospital our outpatient surgery center services, ask if the *provider* is a *Sanford SELECT contracted provider* or call Sanford Health Plan for verification. When a *provider* no longer participates with Sanford Health Plan, you must choose to receive your health services from among the remaining *Sanford SELECT contracted providers.*

For the supplemental coverage under Sanford SELECT to apply, inpatient hospitalization services or outpatient surgery services described in this Policy must be received from *Sanford SELECT contracted providers* (i.e. hospital and outpatient surgery centers) who are part of the Sanford SELECT network. You may go to *non-contracted* facilities to receive inpatient hospitalization or outpatient surgery services, but no coverage for facility expenses will be provided under this Policy, unless health services meet Sanford Health Plan's and/or *Medicare's* definition of an *emergency.* Follow-up care or scheduled care following an *emergency* must be received from a *Sanford SELECT contracted provider.*

Sanford SELECT supplemental coverage applies to services provided in the physician's office, in another office setting, or a skilled nursing facility. There are no network restrictions on benefits for services received in a non-hospital or non-outpatient surgery center setting beyond standard limitations of this policy.

Coverage is subject to all other terms and conditions of the Policy and health services must be *medically necessary* as determined by Medicare or Sanford Health Plan. The fact that a provider has performed, prescribed or recommended a service or that a service is the only available treatment does not mean that the service is *medically necessary* and/or a covered *benefit.*

The words "you," "your" and "yourself' in this Policy refer to the *member. "We"* refers to Sanford Health Plan.

Many words used in this Policy have special meanings. These words appear in italics and are defined for you in the Section titled <u>Definitions</u>. Use these definitions to understand this Policy.

What you must do:

1. **READ THIS POLICY CAREFULLY. This Policy should be read in its entirety. Many provisions of this Policy are interrelated; therefore, reading just one or two provisions may not give you a complete understanding of the coverage described under this Policy.**

2. Confirm that your *provider (hospital or outpatient surgery center) participates* with Sanford SELECT;

3. Identify yourself to the *Sanford SELECT contracted provider* as a Sanford SELECT *member* by showing your Sanford SELECT identification card and *Medicare* card each time you request health services. If you do not show your card, *providers* have no way of knowing that you are a Sanford SELECT *member* and you may receive a bill for health services or be required to pay at the time you receive health services.

   Possession and use of a Sanford SELECT identification card will not guarantee coverage. The Sanford SELECT card will identify that you have selected Sanford Health Plan to supplement your Medicare covered services. You will, however, need to present your Medicare card when you request health services. Failure to show your Medicare card will delay the processing of your claims for health care services. Sanford Health Plan cannot process any claims for Medicare eligible services until Medicare has reviewed the claim and issued a payment determination.

4. Pay any charge not covered by *Medicare* or Sanford Health Plan.

5. Pay to Sanford Health Plan *premiums* for which you are responsible. All *premiums* are due and payable as outlined in the Section titled <u>Paying Your Premiums of this Policy</u>.

How to Contact Us: Call the Member Services Department between the hours of 8:00am to 5:00pm CST Monday through Friday at (605) 328-6800 or toll free at 1-800-752-5863**.** For hearing impaired members: call TTY line (605) 328-6869.

B. Definitions

The words listed below have the following meanings when used in this Policy and its amendments.

Term	Definition
Accident.	Bodily injury or injuries caused by an accident.
Benefits.	The health care services or supplies approved by Sanford Health Plan as eligible for coverage, as described in this Policy and any amendments.
Benefit Period.	A Medicare term used to measure your use of services. A benefit period begins with the first day of a Medicare-covered inpatient hospital stay and ends when you have been out of a hospital or other facility for sixty (60) days in a row (including the day of discharge).
Claim.	An invoice, bill or itemized statement for *benefits* provided to you.
Coinsurance.	The portion or percentage of *Medicare* Part A or *Medicare* Part B medical expenses that *Medicare* requires beneficiaries to contribute toward the cost *of Medicare* coverage. *Medicare* Part A and *Medicare* Part B *coinsurance* amounts will vary based on the nature of services received.
Continuous Coverage.	The maintenance of continuous and uninterrupted qualifying coverage by an eligible individual. An eligible individual is considered to have maintained *continuous coverage* if enrollment begins under the Policy within 63 days of termination of the previous qualifying coverage.
Cosmetic.	Services and procedures that improve physical appearance but do not correct or improve a physiological function and that are not *medically necessary,* unless the service and/or procedure meet the definition of *reconstructive.*
Custodial Care.	Care that is primarily for the purpose of helping you with daily living or meeting personal needs and that can be provided safely and reasonably by people without professional skills or training. Much of the care provided in nursing homes to people with chronic, long-term illness or disabilities is considered *custodial care.* For example, *custodial care* services include, but are not limited to, help in walking and getting in and out of bed, and assistance in bathing, dressing, eating and taking medicine. *Medicare* does not pay for *custodial care* when that care is the only care needed.

Deductible. The flat dollar amount of *Medicare* Part A or *Medicare* Part B medical expenses that *Medicare* requires beneficiaries to contribute toward the cost of *Medicare* coverage.

Eligible Expense. The health care expenses recognized as reasonable and *medically necessary* by *Medicare* and are within the scope of *Medicare* coverage.

Emergency. Inpatient and outpatient services that are needed to evaluate or stabilize an emergency medical condition and that are provided by a qualified provider.

Emergency Medical Condition. A medical or behavioral condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

a) placing his or her health (or the health of an unborn child or others) in serious jeopardy; or
b) serious impairment of bodily functions, or
c) serious dysfunction of any bodily organ or part, or
d) serious disfigurement.

Hospital. A *Medicare*-certified facility that provides diagnostic, medical, therapeutic and surgical services by, or under the direction of physicians and with 24 hour R.N. nursing services. The term "Hospital" specifically excludes rest homes, places which are primarily for the care of convalescents, nursing homes, skilled nursing facilities, intermediate care facilities, health resorts, clinics, doctor's offices, private homes, ambulatory surgical centers, residential or transitional living centers, or similar facilities.

Inpatient. An uninterrupted stay of 24 hours or more in a hospital, skilled nursing facility or licensed acute care facility.

Investigative Services. A drug, device, medical treatment, diagnostic procedure, technology, or procedure for which reliable evidence does not permit conclusions concerning its safety, effectiveness, or effect on health outcomes. Sanford Health Plan will make its determination based upon an examination of the following reliable evidence, none of which shall be determinative in and of itself:

a) whether there is final approval from the appropriate government regulatory agency, if required;
b) whether there are consensus opinions and recommendations reported in relevant scientific and medical literature, peer-reviewed journals, or the reports of clinical trial committees and other technology assessment bodies; and whether there are consensus opinions of national and local health care providers in the applicable specialty or subspecialty that typically manages the

condition as determined by a survey or poll of a representative sampling of these providers.

***Sanford Health Plan Contracted Provider*.** A term used to describe a *hospital or outpatient surgery center* that has entered into a written agreement with Sanford Health Plan or has made other arrangements with Sanford Health Plan to provide health services to you. The participation status of *providers* will change from time to time. It is your responsibility to verify the participation status of a *provider.*

Medically Necessary. Health care services that are appropriate, in terms of type, frequency, level, setting, and duration to the *Member's* diagnosis or condition and diagnostic testing and preventive services. *Medically necessary* care must meet the following criteria:

1. be consistent with generally accepted practice parameters as determined by health care *providers* in the same or similar general specialty as typically manages the condition, procedure or treatment at issue; and
2. help to restore, improve or maintain your health; and
3. prevent deterioration of your condition; and
4. prevent the reasonably likely onset of a health problem or detect an incipient problem; and
5. not considered investigative.

Medicare. The insurance program established under Title XVIII of the States Social Security Act, as amended. *Medicare* Part A pays for *inpatient hospital* care, *inpatient* care in a *skilled nursing facility,* home health care and hospice care. *Medicare* Part B pays for doctors' services, outpatient *hospital* services, durable medical equipment, and a number of other medical services and, supplies that are not covered by *Medicare* Part A.

Medicare-eligible expenses (services). Health care expenses covered by Medicare to the extent recognized as reasonable and medically necessary by Medicare.

Member. A person who is enrolled under this Policy.

Mental Disorder. A physical or mental condition having an emotional or psychological origin, as defined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM").

Non-contracted *A* term used to describe a *hospital or outpatient surgery center* **not under contract as a** *Sanford SELECT contracted provider.*

Physician. A Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.) or Doctor of Optometry (O.D.) practicing within the scope of his or her licensure.

Premium. The periodic payment required for each *member* in accordance with this *Policy.*

Prescription Drug. A drug approved by the Federal Drug Administration ("FDA") for the prescribed use and route of administration.

Provider. A health care professional or facility licensed, certified or otherwise qualified under state law to provide health care services.

Reconstructive. Surgery to rebuild or correct:

1. A body part when such surgery is incidental to or following surgery resulting from injury, sickness or disease of the involved body part; or
2. A functional defect determined by a *physician* to have been present at birth and that adversely affects your ability to perform routine activities of daily living.

Restorative. Surgery to rebuild or correct a physical defect that has a direct adverse effect on the physical health of a body part, and for which the restoration or correction is *medically necessary.*

Service Area. The geographic area in which Sanford Health Plan is approved to provide coverage for *benefits* under Sanford SELECT includes the following counties: Cottonwood, Jackson, Lac Qui Parle, Lincoln, Lyon, Martin, Murray, Nobles, Pipestone, Redwood, Rock, Watonwan and Yellow Medicine. **You must reside permanently within the *service area* to be eligible for coverage under this Policy.** You must notify Sanford Health Plan of the date you move out of the *service area.*

Skilled Care. Services that must be furnished by or under the supervision of trained medical or paramedical personnel to assure the safety of the patient and achieve the medically desired result. A service is not classified as skilled merely because it is performed by a trained medical or paramedical person. A service that can be safely and adequately self-administered or performed by the average, rational, nonmedical person, without the direct supervision of trained medical or paramedical personnel, is a nonskilled service without regard to who actually provides the service.

Skilled Nursing Facility. A place which, by law provides care and treatment to persons who are convalescing as resident bed patients' from a sickness or injury after a *Hospital* stay. It must also:

1. Qualify as a *Skilled Nursing Facility* under *Medicare*;
2. Have a registered graduate nurse (R.N.) on duty or on call in the facility at all times to supervise 24-hour nursing service;

3. Have a *Physician* to supervise the operation of the place, and
4. Maintain daily medical records for all patients.

Its main purpose must not be to provide Custodial Care, rest-care for the aged or treatment such as that provided by a clinic or sanitarium.

Supportive Care. Services that are generally repetitive and duplicative and, due to the physical stability of your condition, do not need to be provided or directed by skilled medical professionals.

C. Description of Supplemental Benefits

This Section describes our coverage for the health services outlined below that is subject to the terms, conditions, exclusions and limitations of this Policy.

Health services must be *medically necessary* and must be provided by a *Sanford SELECT contracted provider* (except under *emergency* conditions or when services are not available or provided by a *Sanford SELECT contracted provider).*

If *Medicare* denies coverage of a particular service, that service will not be covered by Sanford Health Plan, unless it is otherwise specifically identified as a covered *benefit* under this Policy.

Coverage for the treatment of conditions resulting from an accident shall be covered the same as any other sickness.

1. Medicare Part A Supplemental Benefits

a. Hospital Inpatient Benefits

Sanford Health Plan will provide coverage for 100% of the *Medicare* Part A *deductible* and *coinsurance* amounts for *hospital inpatient* services and 100% of all *Medicare* Part A *eligible expenses* for *hospital inpatient* services not covered by *Medicare,* as follows:

(i) *Medicare* Part A *eligible expenses* for *hospital inpatient* services from the 61st to the 90th day in any *Medicare* benefit period.

(i) *Medicare* Part A *eligible expenses* for *hospital inpatient* services for each *Medicare* lifetime *inpatient* reserve day used; and

(ii) When all *Medicare hospital inpatient* coverage and lifetime reserve days are used up, Sanford Health Plan will pay for *eligible expenses* for *hospital inpatient* services for an unlimited number of days, when the *inpatient* services continue to otherwise meet *Medicare* guidelines and are *medically necessary*. You must use any available lifetime reserve days.

2. Skilled Nursing Facility Inpatient Benefits

Sanford Health Plan will provide coverage for the daily *copayment* amount of *Medicare* Part A *eligible expenses* incurred for *inpatient services* in a *Medicare*-certified *skilled nursing facility* as follows:

a. 21st day through the 100th day in a *Medicare* benefit period for post-hospital *skilled nursing facility* care eligible under *Medicare* Part A. Services are covered only after transfer to a *skilled nursing facility* occurs after discharge from the *hospital* in which you were confined for not less than 3 consecutive calendar days.

Sanford Health Plan will provide coverage for 80% of the medical expenses incurred for the 101st day through the 120th day in the calendar year for post-hospital skilled nursing facility care when Medicare guidelines for skilled care are met.

3. Blood Transfusions

Sanford Health Plan will provide coverage under *Medicare* Part A and *Medicare* Part B for the first three pints of blood (whole blood or units of packed red blood cells) unless replaced in accordance with federal regulations.

4. Medicare Part B Deductible

Sanford Health Plan will provide coverage for the *Medicare* Part B calendar year *deductible.*

5. Medicare Part B Medical Insurance

Sanford Health Plan will provide coverage for the *coinsurance* and *copayment* amount under *Medicare* Part B regardless of hospital *inpatient services*. Sanford Health Plan will also provide 100% coverage for any charges above the *Medicare* fee schedule for which a provider can lawfully bill. This includes but is not limited to:

a) Office visits.
b) Outpatient hospital, ambulatory care or surgical facility services.
c) Pre-scheduled outpatient procedures including lab tests, diagnostic tests and x-rays.
d) *Medicare* eligible physical, occupational and speech therapy.
e) Durable medical equipment.
f) Prosthetics.
g) Chiropractic services. The only *Medicare* eligible chiropractic service is manual manipulation of the spine to correct a subluxation.
h) *Medicare* eligible ambulance services.
i) The following *Medicare* eligible preventive and routine screening procedures:
    i) an annual mammogram;
    ii) pap smears and pelvic exams received once every three years (more if certain conditions are met); and
    iii) an annual screening test for the detection of colorectal cancer that may include preventive screening tests at a frequency considered, according to *Medicare* guidelines, to be medically appropriate.
    iv) *Medicare* eligible bone density measurement screening services for women who are at high risk for osteoporosis.

D. Description of Benefits for Services Not Covered or Limited by Medicare

Sanford Health Plan will provide coverage for the *benefits* described in this Section, as outlined below.

The following health services must be *medically necessary* and must be provided by *Sanford SELECT contracted providers* (except in the case of *emergencies* or services not available or provided by a *Sanford SELECT contracted provider).*

1. Foreign Travel Emergency Care

Sanford Health Plan will provide coverage for 80% of the *hospital* and medical expenses and supplies incurred as a result of a medical *emergency* during travel outside the United States.

2. Treatment for Lyme Disease

Sanford Health Plan will provide coverage for 80% of the medical expenses and supplies incurred for treatment of diagnosed Lyme disease.

3. Immunizations and Routine Screening Procedures

In addition to the coverage described in the Section titled Description of Supplemental Benefits, Subsection 4.g., Sanford Health Plan will provide coverage for 100% of the medical expenses and supplies incurred for immunizations and routine screening procedures for cancer, including mammograms, pap smears and prostate cancer screening, and routine screening procedures for diabetes as required by law.

4. Preventive Health Services

In addition to the coverage described in the Section titled Description of Supplemental Benefits, Subsection 4.g., Sanford Health Plan will provide coverage for the actual charges up to 100% of the *Medicare* approved amount for preventive health services, including an annual clinical preventive medical history and annual health assessment that may include preventive screening tests at a frequency considered to be medically appropriate. The following are eligible preventive services:

a. Routine health exams include the following:
   - i) fecal occult blood test and/or digital rectal examination;
   - ii) dipstick urinalysis for heaturia, bacteriuria, and proteinauria;
   - iii) serum cholesterol screening every five years;
   - iv) thyroid function test; and
   - v) diabetes screening.

b. Well child and child health supervision services, including pediatric preventive services, routine immunizations, developmental assessments and laboratory services appropriate to the age of the child from birth to 72 months.

c. Prenatal and postnatal care and exams.

d. Routine screening procedures for cancer.

e. One routine refractive eye exam and routine hearing exam per calendar year.

f. Professional voluntary family planning services.
g. Immunizations.

5. Reconstructive and Restorative Surgery

Sanford Health Plan will supplement *Medicare* coverage for 80% of the medical expenses and supplies incurred for *reconstructive* and *restorative* surgery services.

6. Port Wine Stain Treatment

Sanford Health Plan will provide coverage for 80% of the medical expenses and supplies incurred for treatment to lighten or remove the coloration of a port wine stain.

7. Temporomandibular Joint (TMJ) Disorder

Sanford Health Plan will provide coverage for 100% of the medical expenses and supplies for the surgical and non-surgical treatment of confirmed, existing TMJ disorder. Coverage for treatment of TMJ disorder includes coverage for the treatment of craniomandibular disorder (CMD). Dental services which are not required to directly treat TMJ or CMD are not covered.

8. Scalp Hair Prostheses

Sanford Health Plan will provide coverage for 80% of the medical expenses and supplies incurred for scalp hair prostheses due to alopecia areata, to a maximum benefit of $350 per calendar year.

9. Phenylketonuria ("PKU") Treatment

Sanford Health Plan will provide coverage for 80% of the medical expenses and supplies incurred for the dietary medical treatment of phenylketonuria ("PKU").

10. Diabetes Supplies

a. Sanford Health Plan will provide coverage for 100% of the medical expenses incurred for diabetic supplies including disposable insulin syringes, lancets, lancet devices, alcohol swabs and glucose test strips. These supplies are dispensed in a 30 consecutive day supply or as prescribed by your *provider*. To receive coverage for these items it must be included in the Health Plan formulary and must be purchased from a *Sanford Health Plan contracted* pharmacy.

b. Sanford Health Plan will provide coverage for 80% of the expenses incurred for oral or injectable insulin. The insulin will be dispensed in a 30 day supply or as prescribed by your *provider*. To receive coverage for these items it must be included in the Health Plan formulary and must be purchased from a *Sanford Health Plan contracted* pharmacy.

11. Diabetes Education

Sanford Health Plan will supplement *Medicare* coverage for 80% of the medical expenses incurred for diabetes self-management training and education, including medical nutritional therapy, received from a *provider* in a program consistent with the national standards for such education as established by the American Diabetes Association.

12. Mental Health

a. **Outpatient Services.** When *Medicare* pays for the mental health services described below, Sanford Health Plan will provide coverage for the *Medicare* Part B coinsurance amounts you incur for *Medicare* approved charges for those services in excess of the Part B deductible. This benefit provides outpatient professional mental health services for evaluation, crisis intervention, and treatment of mental and nervous disorders when the services meet *Medicare* guideline criteria.

- evaluations and diagnostic services for primary treatment; and
- therapeutic services including psychiatric and psychological services; and
- relationship and family counseling services for which the primary purpose is the treatment of the patient's condition; and
- treatment of serious and persistent disorders.

b. **Inpatient Services.** When *Medicare* pays for your stay in a hospital or licensed residential treatment facility, Sanford Health Plan will provide coverage for the *Medicare* Part A coinsurance amounts you incur during the *Medicare* hospital coinsurance period for the inpatient services described below. When all *Medicare* hospital inpatient coverage, including lifetime reserve days, have been paid to you, we cover 100% of all *Medicare* Part A eligible expenses for your continued stay in a hospital, which is medically necessary care. When *Medicare* pays for your stay in a psychiatric hospital, we cover the *Medicare* Part A coinsurance amounts you incur *Medicare* approved charges for those services in a hospital of licensed residential treatment facility and processional services for treatment of mental and nervous disorders. Care received in an inpatient hospital eating disorder unit for an eating disorder will be covered under this inpatient mental health services benefit. This does not include medical stabilization.

- semi-private room and board; and
- *hospital* or facility-based professional services and;
- attending *physician* services.

There is a 190-day *Medicare* lifetime maximum for inpatient mental health treatment in a *Medicare*-certified psychiatric hospital. Inpatient mental health services in a hospital or other approved treatment facility are covered for an unlimited number of days. You must use available days from your lifetime reserve of 60 days.

c. **Day Treatment Services.** When *Medicare* pays for the eligible day treatment services in a hospital or licensed residential treatment facility, we cover the annual *Medicare* Part B coinsurance amounts you incur for *Medicare* approved charges for

those services in excess of the Part B deductible. This benefit provides day treatment services in a hospital or licensed residential treatment facility and professional services for treatment of mental and nervous disorders.

13. Substance Abuse Treatment

a. **Outpatient Services.** When *Medicare* pays for professional services for diagnosis and treatment of alcohol or drug abuse, Sanford Health Plan will provide coverage for the *Medicare* Part B coinsurance amounts you incur for *Medicare* approved charges for those services in excess of the Part B deductible. This benefit provides outpatient professional mental health services for evaluation, crisis intervention, and treatment of mental and nervous disorders when the services meet *Medicare* guideline criteria.

Coverage for outpatient substance abuse services is limited to 130 hours per calendar year. Treatment is typically received in three-hour sessions. One session counts as three hours of treatment. If treatment is rendered on a group basis, two group therapy sessions count as three hours of treatment.

b. Inpatient Services. When *Medicare* pays for your stay in a hospital or licensed residential treatment facility and professional services for treatment of alcohol or drug abuse, Sanford Health Plan will provide coverage for the *Medicare* Part A coinsurance amounts you incur during the *Medicare* hospital coinsurance period for the inpatient services described below. Inpatient services are limited to emergency care, detoxification, treatment planning and rehabilitative care.

When all *Medicare* hospital inpatient coverage, including lifetime reserve days, have been paid to you, we cover 100% of all *Medicare* Part A eligible expenses for your continued stay in a hospital, which is medically necessary care.

- semi-private room and board; and
- *hospital* or facility-based professional services; and
- attending *physician* services.

Coverage for substance abuse *inpatient benefits* is limited to up to 73 days per calendar year.

c. Day Treatment Services. When *Medicare* pays for your stay in a hospital or licensed residential treatment facility and professional services for treatment of alcohol or drug abuse, Sanford Health Plan will provide coverage for the charges incurred for eligible services. Each day of day treatment will count as half day toward the 73-day maximum for *inpatient* services for alcohol or drug abuse.

14. Chiropractic Services

For chiropractic services, other than as described in the Section titled Description of Supplemental Benefits, Subsection 4.e, Sanford Health Plan will provide coverage for 80% of the medical expenses and supplies incurred to diagnose and to treat, by manual manipulation, neuro-musculoskeletal conditions related to the spine or joint.

15. Ventilator Dependent Persons

Sanford Health plan will provide services for the first 120 hours of confinement for services that are provided by a private duty nurse for a ventilator dependent person in the hospital. The private duty nurse shall perform only the services of communicator or interpreter for you during the transition period to assure adequate training of hospital staff to communicate with you.

E. Services from Non-Contracted Providers

For the supplemental coverage under Sanford SELECT to apply, the health services described in this Policy must be received from *Sanford SELECT contracted hospital and outpatient surgery center providers*.

NOTE: These non-contracted provider referral procedures do not apply in *emergency* situations or while you are traveling outside the service area.

You will be responsible for all costs associated with your care that is not covered by *Medicare,* if you elect to use *non-contracted providers* for:

1. non-*emergency* services; or
2. services which are available or provided by a *Sanford SELECT contracted provider*.

Prior to admission to a *non-contracted provider for inpatient services* or *outpatient surgery,* you should contact Sanford Health Plan's Member Service Department at (605) 328-6800 or 1-800-752-5863 (TTY (605) 328-6869). A Member Service Representative will confirm whether the required services are available from a *contracted provider*, and if not available, will assist you in locating a hospital or outpatient surgery center that provides the necessary service. Utilizing Sanford Health Plan's Member Services prior to use of a *non-contracted provider* eliminates the need for retrospective inquiry as to the legitimacy of the filed claim.

Sanford Health Plan will provide notification of approval or denial of coverage to you and your attending *provider* within ten (10) business days after the date your request was received, provided all information reasonably necessary to make a decision has been made available to Sanford Health Plan. Your attending *provider* may request an expedited review from Sanford Health Plan if the *provider* believes that an expedited review is warranted. In the case of an expedited review, Sanford Health Plan will inform both you and your attending *provider* of Sanford Health Plan's decision no later than seventy-two (72) hours from the time of the initial request. If Sanford Health Plan does not approve your request for prior authorization, you have the right to appeal Sanford Health Plan's decision as described in the Section titled If You Have A Complaint.

F. Exclusions

In addition to the items already listed as **"Not covered,"** the following services, supplies and associated expenses are not covered except as otherwise determined by Sanford Health Plan.

1. Services that are not *medically necessary,* as determined by Medicare and/or Sanford Health Plan.

2. Charges billed by a *non-contracted provider* that are not in compliance with generally accepted coding and reimbursement guidelines including those of the American Medical Association (AMA), the Centers for Medicare & Medicaid Services (CMS) and the community.

3. The purchase, replacement or repair of eyeglasses, eyeglass frames, or contact lenses when prescribed solely for vision correction, and their related fittings, for non-*Medicare* eligible lenses or contacts.

4. Hearing aids and other devices to improve hearing and their related fittings.

5. A drug, device, or medical treatment or procedure that is *investigative* except those defined by *Medicare.*

6. Services or drugs used to treat conditions that are *cosmetic* in nature, unless otherwise determined to be *reconstructive.*

7. *Custodial care, supportive care,* unskilled nursing or unskilled rehabilitation services.

8. Non-medical self-care or self-help training.

9. Respite or rest care, except as otherwise covered in this Policy.

10. Services by persons who are family members or share your legal residence.

11. Services prohibited by law or regulation, or illegal under the laws of the State of Minnesota.

12. Services for which coverage is available, if proper claim were made, under worker's compensation.

13. Autopsies.

14. Services to treat an injury determined by the Veterans Administration to be an injury incurred or aggravated while on military duty.

15. Enteral feedings and other nutritional and electrolyte substances, except for the dietary medical treatment of phenylketonuria ("PKU") or when it is your only source of nutrition.

16. Personal comfort or convenience items or services (including home monitoring devices such as Life Line).

17. Meals delivered to your home.

18. Services or supplies not directly related to your care.

19. Exams, other evaluations and/or other services for employment, insurance, licensure, judicial or administrative proceedings or research, except as an *emergency* examination of a child ordered by judicial authorities, or as otherwise covered under the Policy.

20. Remedial education and other services beyond the initial evaluation to diagnose mental retardation or learning disabilities.

21. Travel, transportation or living expenses.

22. Charges for duplicating and obtaining medical records from *non-contracted providers.*

23. Air conditioners and humidifiers.

24. Dental braces, except as covered for cleft lip and cleft palate.

25. Physical, occupational or speech therapy when there is no reasonable expectation, in accordance with *Medicare* guidelines, that your condition will improve over a predictable period of time.

26. Treatment for malocclusion or bruxism.

27. Occlusal adjustment or occlusal equilibration.

28. Services and drugs to treat nicotine addiction.

29. Reversal of voluntary sterilization.

30. Educational classes, programs or seminars, including those for smoking cessation and weight loss, except as described in the Section titled Description of Benefits for Services Not Covered or Limited by *Medicare*.

31. Dental prostheses.

32. Dental implants (tooth replacement).

33. Orthodontic treatment.

34. Health services rendered outside the *service area* and received from a *non-contracted provider,* unless rendered in an *emergency* or when urgent care is necessary or as otherwise described in this Policy.

35. Services received before your coverage under this Policy becomes effective.

37. Services received after your coverage under this Policy ends.

36. Photographs, except for the condition of multiple dysplastic syndrome.

37. Massage therapy, therapeutic acupuncture and homeopathic medicine.

38. Services received from a naturopath.

39. Routine foot care, except for diabetes, peripheral vascular disease, peripheral neuropathies or blindness.

40. Supportive devices for the feet, except for *Medicare* eligible orthopedic or therapeutic shoes.

41. Private duty nursing.

42. Nursing care on a full-time basis in your home.

43. Outpatient *prescription drugs* except as otherwise covered under *Medicare*.

44. At-home recovery services.

45. Hypnosis.

49. Refractive eye surgery.

46. Coverage for costs associated with translation of medical records and claims to English.

50. Any charge for services or articles the provision of which is not within the scope or authorized practice of the institution or individual rendering the services or articles.

51. Any charge for care for injury or disease either (i) for which benefits are payable without regard to fault under coverage statutorily required to be contained in any motor vehicle, or other liability insurance policy or equivalent self-insurance, or (ii) for which benefits are payable under another policy of accident and health insurance, *Medicare,* or any other governmental program except as otherwise described in the Policy.

52. Lymerix vaccine, except in certain circumstances.

G. How To Submit A Claim

1. **Claims for benefits from Sanford SELECT contracted providers.**
   You do not need to file a claim for your services. By law, physicians or other suppliers must fill out claim forms for you and send them to Medicare, even if they do not accept assignment. We will accept notice from Medicare Carriers on claims submitted on your behalf by physicians and suppliers or you may submit the Medicare Summary Notice (MSN). Notice of claims should include your name and policy number.

   You should always make sure your providers know that you have supplemental coverage with us. When you receive health services in your home state, Medicare will automatically send your claim to us.

2. **Out-of-State Service Claims**
   If you receive health services outside of your state, the provider will submit your claim to the Medicare office in that state. After the office processes the claim, you will receive a Medicare Summary Notice (MSN). If the *Notes* section of the MSN says that the information is being sent to your private insurer, we will automatically receive the MSN. If the MSN does not say your private insurer is receiving the information, you need to send the MSN to us so we can process your Medicare supplement benefits. Be sure your identification number and mailing address are shown accurately on the MSN form. You do not need to complete a claim form, just send the MSN, and keep a copy for your own records. Send your MSN to:

   Sanford Health Plan
   Attn: Medicare SELECT
   P.O. Box 91110
   Sioux Falls, SD 57109-1110

Claims **for services rendered in a foreign country will require the following documentation:**

1. claims submitted in English with the currency exchange rate for the date health services were received;
2. itemization of the bill or *claim;*
3. the related medical record (submitted in English);
4. proof of your payment of the *claim;*
5. a complete copy of your passport and airline ticket; and
6. such other documentation as Sanford Health Plan may request.

NOTE: Sanford Health Plan will not reimburse you for costs associated with translation of medical records or *claims.*

3. **Time limits:**
   Your *claim* must be submitted within the timelines specified by *Medicare.*

   If you have a complaint or disagree with a decision by Sanford Health Plan, you may follow the complaint procedures outlined in the Section titled If You Have A Complaint or you may initiate legal action at any point. However, you may not bring legal action more than 3 years after Sanford Health Plan has made a coverage determination regarding your *claim.*

H. Non-Duplication Provisions

1. Non-Duplication with *Medicare:*
This Policy does not provide coverage for any services or supplies that *Medicare* has paid or would pay if coverage were requested by you or for which you could have received payment if you had been enrolled in *Medicare.*

2. Non-Duplication with other Sanford Health Plan coverage:
If you are covered under more than one Sanford Health Plan contract or policy, coverage will be provided under all Sanford Health Plan contracts or policies only to the extent that the combined coverage does not exceed the total charges for the health services received.

3. Coordination of *Benefits:*
If you have other health coverage in addition to this Policy (such as group or group-type coverage, other governmental coverage, worker's compensation, no-fault automobile), Sanford Health Plan or the other coverage may be entitled to coordinate *benefits.*

4. Subrogation
If for any reason we make payment under this policy in error, we may recover the amount we paid. Sanford Health Plan is subrogated to all of yor rights against those other parties according to state law (Minnesota Statutes 62A.095 and 62A.096).

Once you receive benefits under this policy arising from an illness or injury, we will assume any legal right you have to collect compensation, damages, or any other payment related to the illness or injury, including benefits from any of the following:

- The responsible person’s insurer;
- Uninsured motorist coverage;
- Underinsured motorist coverage; or
- Other insurance coverage.

You agree to the following:

- You will let us know about any potential claims or rights of recovery related to the illness or injury;
- You will furnish any information and assistance that we may reasonably require to enforce our rights under this policy;
- You will do nothing to prejudice our rights and interests;
- You will not compromise, settle, surrender, or release any claim or right of recovery described above, without getting our written permission; and
- You must reimburse us to the extent of benefit payments made under this policy if payment is received from the other party or parties.
- You must notify us if you have the potential right to receive payment from someone else.
- You must cooperate with us to ensure our rights to subrogation are protected.

I. Enrollment

This Section describes who can enroll and how to enroll.

1. Who can enroll:

To be eligible to enroll for coverage you must:

a. Be eligible for Medicare and complete all application documents provided by Sanford Health Plan; and
b. Enrolled in *Medicare* Parts A and B; and
c. Reside permanently within the *service area*.

2. The date your coverage begins:

We must receive your Application for Coverage prior to the requested effective date. If you are eligible for enrollment, your coverage begins at 12:01 a.m. on the first day of the month following approval of your application by Sanford Health Plan or in which Sanford Health Plan has notified you in writing that it has approved your application, whichever is earlier.

3. Term of this Policy:

The term of this Policy begins on your effective date and ends on the last day of the calendar month following your termination date, as designated in your application for coverage under this Policy.

4. Your contract:

The documents that make up your contract with us consist of:

- The application you submitted,
- This benefits policy, and
- Any amendments.

5. Time Limit On Certain Defenses:

After 2 years from the effective date of this policy no misstatements, except fraudulent misstatements, made by the you in the application for such policy shall be used to void the policy or to deny a claim for loss incurred or disability commencing, after the expiration of such 2 year period.

J. Paying Your Premiums

This Section describes when and how to pay your premiums.

Upon acceptance of enrollment under this Policy, you will be responsible for payment of premium to Sanford Health Plan. As part of the enrollment process, you were given the opportunity to select one of the following payment options:

- Annual payment by check (once a year),
- Semiannual payment by check (twice a year),
- Quarterly payment by check (four times a year), or
- Monthly payment by automatic account withdrawal (twelve times a year).

1. Premium Changes.
We can only change your premium rate if we change it for all policies of the same class in this state. We will tell you at least 30 days in advance of any change in premium rate due to a new table of rates or a change in *Medicare's* benefit structure. Since benefits are tied to *Medicare's deductible* and *coinsurance* amounts, premium and benefit changes are expected to occur each January.

We have the right to change your rates upon an increase in your age. Premium changes due to an increase in Member's age 65 and older automatically occur the first day of the month following your birth month in which you enter a new age increment. Premium changes due to a Member turning age 65 automatically occur on the first day of their birth month.

2. Payment Of Premium.
Each premium is due at the end of the period for which the proceeding premium was paid. You must make premium payments in the required amount according to our agreed schedule of payments for the duration of the contract.

3. Lapse in Coverage.
If any renewal premium is not paid within the time allowed for payment, coverage will lapse on the last day of the period for which the premium is paid. If the premium is not paid by that date, the grace period will begin.

4. Grace Period.
A grace period of 31 days will be granted for the payment of each renewal premium. During this grace period, the policy shall continue in force.

5. Reinstatement.
If you fail to pay the renewal premium within the 31-day grace period, your coverage will lapse. You may request reinstatement of this policy by submitting an *Application For Coverage* no later than sixty (60) days after the due date for the premium payment, unless:

- You have left the State or the service area; or
- You have applied for reinstatement on two (2) or more prior occassions.

We will give you written notice of our decision to accept or deny your application. If we do not mail to you a notice of our disapproval within forty (40) days after the

issuance of the conditional receipt, your Policy will be reinstated on the forty-fifth (45) day following such issuance. If reinstated, this policy will cover only claims that occurred after the date of reinstatement.

Any premium accepted in connection with a reinstatement shall be applied to a period for which premium has not been previously paid. In order to be reinstated, you must pay any premiums due from your previous enrollment in the plan. We will accept payment of a renewal premium and reinstate the policy

In addition to your Sanford Health Plan *premium,* you are responsible for paying both your *Medicare* Part *B premiums* to *Medicare* and any applicable *Medicare* Part A premium.

6. When your Sanford Health Plan *premiums* are due:

For the automatic payment option, premium deductions occur the 10th working day of every month.

For payment by check, you can mail your payment to:

Sanford Health Plan
Attn: Medicare SELECT
PO Box 91110,
Sioux Falls, SD 57109.

You may hand deliver payments to the following address:

Sanford Health Plan
1100 East 21st St., Suite 600
Sioux Falls, SD 57105

If your coverage is terminated or cancelled, Sanford Health Plan will refund to you any unearned *premium* if the unearned *premium* is for one month or more.

K. Ending Your Coverage

1. **When your coverage ends:**
   Your coverage will end immediately if any of the following occurs:
   a. You fraudulently misrepresent or conceal material facts in your application. If this happens, we will recover any claim payment we made, minus any premium paid.
   b. You fail to pay your premium by the end of the 31-day grace period.
      (i) If you pay by automatic account withdrawal, your coverage will be terminated upon Plan notification of non-sufficient funds in your account.
      (ii) If you pay by check quarterly, semiannually or annually, you coverage will be terminated the first of the month following the month for which premium was paid.
   c. You terminate this policy by giving written notice of termination to Sanford Health Plan. Your coverage will be terminated on the first of the month following the month in which we receive your written notice.
   d. You are no longer eligible according to the criteria set forth under Section I titled Enrollment in this Policy.

2. **Moves outside the *service area*:**

   In the event you move outside the Network Hospital Service Area, or in the event that the Medicare SELECT program is discontinued for whatever reason, you will have the opportunity to purchase, without evidence of insurability, a Medicare supplement policy which does not contain restrictions on the use of providers.

3. **Effects of Termination**
   If your policy is terminated for misrepresentation or the concealment of material facts we will not pay for any services or supplies provided after the date the policy is terminated; we will retain legal rights, including the right to sue based on concealment or misrepresentation; and we may, at our option, declare the policy void.

   If, at any time while your insurance under this policy is in effect, we become aware that you are no longer enrolled in both *Medicare* Parts A and B, we will notify you and you will need to provide the appropriate information to us to process any claim. Failure to be enrolled in *Medicare* Parts A and B will result in termination of your policy.

   If your policy is terminated for reasons other than concealment or misrepresentation of material facts, we may stop payment for any services or supplies the day your policy is terminated.

   An exception to this applies in the case of a continuous loss that commenced while this policy is in force. If you receive covered professional or facility services as an inpatient of a hospital or skilled nursing facility on the date this policy terminates, payment for these covered services will end on the earliest of the following:

- the date you are first discharged from the facility following termination of this policy;
- the date the policy coverage period would have ended if this policy had not been terminated, that is, the end of the calendar year during which you were an inpatient;
- the date your Medicare benefits are exhausted if no additional benefits would otherwise have been covered under this policy had it remained in effect; or
- payment of maximum benefits.

You must notify Sanford Health Plan of any changes affecting your status as a *member*.

L. If You Have a Complaint

You may direct any question or complaint to Sanford Health Plan's Member Service at (605) 328-6888 or 1-800-715-8419. Hearing impaired *members* with a TTY phone may contact Member Service at (605) 328-6869. You may also direct complaints related to *benefits* to the Commissioner of Commerce, Minnesota Department of Commerce at (651) 296-2488 or 1-800-657-3602.

1. **Medicare reconsideration process:**

   If your complaint involves a dispute relating to the payment of services covered by *Medicare,* you may file a *Medicare* appeal through *Medicare,* not Sanford Health Plan. The steps to follow in filing a *Medicare* reconsideration are explained in the *Explanation of Medicare Benefits* that can be obtained from the *Medicare* carrier. You may also contact the Social Security Office at 1-800-772-1213.

2. **For coverage issues related to enrollment, termination, *premium* payments or coverage of *Medicare* non-eligible services.**

   You may direct any question or complaint to Member Service at (605) 328-6888 or 1-800-715-8419. Hearing impaired *members* with a TTY phone may contact Member Service at (605) 328-6869. You may also direct complaints at any time to the Commissioner of Commerce, Minnesota Department of Commerce at (651) 296-2488 or 1-800-657-3602.

   Filing a complaint may require that Sanford Health Plan review your medical records as needed to resolve your complaint.

   If your complaint is regarding an initial decision made by Sanford Health Plan, your complaint must be made within one year following Sanford Health Plan's initial decision.

   Sanford Health Plan makes decisions in a timely manner to accommodate the clinical urgency of the situation and to minimize any disruption in the provision of health care. Members, health care providers with knowledge of the Member's medical condition, authorized representative of the Member and/or an attorney may appeal any adverse decision by Sanford Health Plan.

   Audit trails for complaints, appeals and denials are provided by the Plan's information system and an access database which includes documentation of the complaint and/or appeal by date, service, procedure, and Member reason. The denial file includes documentation telephone notification, including the date; the name of the person spoken to; the Member; the service, procedure, or admission certified; and the date of the service, procedure, or admission denial and reason for denial. If the Plan indicates certification by use of a number, the number must be called the "authorization number."

3. **Complaint & Medical Review Determination Process**
   Informal Complaints:
   A Member may submit a complaint to the Member Services Department either orally or in writing. Member Services will make every effort to resolve the complaint. The Member Services Department will investigate the complaint and provide for informal discussions. If the oral complaint is not resolved to the Member's satisfaction within 10 business days of receipt of the complaint, the Plan will provide a complaint form to the Member, which must be completed and returned to the Member Services

Department for further consideration. The Plan will assist the Member in completing this form, or will complete the form and mail it to the Member for a signature, if the Member asks for assistance.

At any time, the Member may also file a complaint with the regarding network benefits, either in writing or by calling (651) 282-5600, or toll free 1-800-657-3916 or the Commission of Commerce regarding Supplemental (Out of Network) benefits at (651) 296-2488, or toll free at 1-800-657-3602.

Formal Complaint Process:
A Member can seek further review of a complaint not resolved through the formal process. The steps in this complaint and appeal process are outlined below.

a. **Formal Complaint Review.** You or your authorized representative may send your written request for review, including comments, documents, records and other information relating to the complaint, the reasons you believe you are entitled to benefits and any other supporting documents to:

Sanford Health Plan of Minnesota
Member Services Department
PO Box 90447
Sioux Falls, SD 57109-0447

We will notify the Member within 10 business days that we received the written complaint, unless the complaint has been resolved to the Member's satisfaction within those 10 business days.

Upon request and at no charge to you, you will be given reasonable access to and copies of all documents, records and other information relevant to your complaint.

We will review your complaint and notify you of our decision in accordance with the following timelines:

(i) For Pre-Service Claims (services for which prior approval by us is a requirement for coverage)
If the request concerns urgent care, you may request an expedited review either orally or in writing. Within 72 hours of such request, a decision on your complaint will be made.
If the request concerns non-urgent services, a decision on your request will be made within 30 calendar days from the date the Plan receives your request.

In certain circumstances, this time period may be extended 14 additional days. In such cases the Plan will notify you in advance, of the reasons for the extension.

(ii) Pre-Service Authorizations requiring Utilization Review for Medical Determinations
If the service request requires *utilization review* for a medical determination, you may request a review either orally or in writing.

(iii) Urgent Request
If the service request is urgent, you may request an **expedited** review. Within 72 hours of such request, a decision will be made via telephone to you and your provider. You and your provider will receive written notification within 1 calendar day of the decision.

(iv) Non-Urgent Request

If the service request concerns non-urgent services, a written decision will be made within 10 business days from the date the Plan receives your request. If the decision is not to certify your request, telephone notification will be made within 1 calendar day to you and your provider.

(v) Post-Service Claims.
A decision on your complaint will be made within 30 calendar days from the date the Plan receives your request. This time period may be extended if you agree.

All notifications described above will comply with applicable law.

4. Appeal Process.
NOTE: When, due to a medical reason, an initial determination is made not to cover a health care service prior to or during ongoing service, an appeal must be submitted to the Plan within 180 days following the written notice of initial determination.

a. **Post-service appeal.** If after the first level of complaint review of a post-service claim, your request was denied, you or your authorized representative may submit a written request for appeal, including any relevant documents, and submit issues, comments and additional information as appropriate to:

Sanford Health Plan of Minnesota
Member Services Department
PO Box 90447
Sioux Falls, SD 57109-0447

The Member Services Department will provide the Member with the option of either a written reconsideration, or a hearing before the Member Appeals Committee either in person or over the phone. Hearings and written reconsideration shall include the receipt of testimony, correspondence, explanations, or other information from the Member, staff persons, administrators, providers, or other persons as deemed necessary for a fair appraisal and resolution of the complaint. During your appeal, upon you request we will provide you, free of charge, reasonable access to all documents, records and other information relevant to your appeal.

We will review your appeal and written notice of the decision and all key findings will be given to the Member within 30 calendar days of the Member Services Department's receipt of the Member's written notice of appeal. If a Member appeals by hearing, written notice of the decision and all key findings will be given to the Member within 45 calendar days of the Member Services Department's receipt of the Member's written notice of appeal.

In certain circumstances, this time period may be extended 14 additional days. In such cases the Plan will notify you in advance, of the reasons for the extension.

b. **Pre-service and concurrent appeal (for utilization review for a medical determination).**
When an initial determination is to deny your request, you or your authorized representative may submit a request for appeal. You may request an expedited review either orally or in writing. Within 72 hours, or as expeditiously as the Member's medical condition requires, of such request, a decision on your complaint will be made via telephone to you and your provider. If the decision is to deny your request, you and your provider will receive written notification of the decision and your right to initiate the external appeals process as soon as practical.

If the complaint concerns non-urgent, services, a written decision on your complaint will be made within 30 calendar days from the date the Plan receives your request.
In certain circumstances, this time period may be extended 14 additional days. In such cases the Plan will notify you in advance, of the reasons for the extension.

5. **External Complaint Procedures:**
   a. If your complaint is denied based on our medical necessity criteria, you have the right to request an external review upon receiving notice of our decision on your complaint. If your complaint is denied for any other reason, you have the right to request external review upon notice of our decision at the completion of internal appeal process. However, if the complaint relates to a malpractice claim, the complaint shall not be subject to the internal appeal process.

   b. To initiate the external review process, you may submit a written request for an external review to the Commissioner of Health (Commissioner of Commerce). This written request must be accompanied by a $25 filing fee payable to the Center for Health Dispute Resolution. This fee may be waived by the Commissioner in cases of financial hardship. We must participate in this external review, and must pay the cost of the review which exceeds the $25 filing fee.

   c. Upon receipt of the request for external review, the external reviewer must provide immediate notice of the review to the Member and to us. Within 10 business days, the Member and the Plan must provide their reviewer with any information they wish to be considered. The Member (who may be assisted or represented by a person of their choice) and the Plan shall be given an opportunity to present their versions for the facts and arguments. Any aspect of the external review involving medical determinations must be performed by a health care professional with expertise in the medical issue being reviewed.

   d. An external review must be made as soon as possible, but no later than 40 calendar days after receipt of the request for external review. Prompt written notice of the decision and the reasons for it must be sent to the Member, the Commissioner of Health or Commissioner of Commerce, and to the Plan.

   e. The results of the external review are non-binding on the Member and binding on the Plan. We may seek judicial review of the decision under certain circumstances.

M. General Disclosure of Provider Payment Methods

For the Sanford SELECT product, *providers* are generally paid for health services as follows:

Physicians. Physicians are generally paid under a fee for service (fee-based) method.

"Fee for service" payment means that after you receive a health service, the physician is paid an amount by *Medicare* and/or Sanford Health Plan for each such service.

Contracted Providers. Sanford Health Plan contracted **hospitals and outpatient surgery centers** receive various fee for service payments. These include:

1. per diem: this is a payment made to a *hospital* for each day of an *inpatient* stay;

2. per stay: this is a payment made to a *hospital* for each *inpatient* stay, regardless of the length of the stay (for *inpatient* stays over a specified number of days, hospitals might receive both a per stay payment and a per them payment);

3. per episode: this is a flat rate payment made to a *hospital* for each episode, regardless of the number of visits or units of service provided; and

4. percentage of charges payments: this is a payment made to a *hospital* based on a percentage of the hospital's charge.

Non-Contracted Providers. When a service from a *non-contracted provider* is covered, the *provider is* paid a fee for service payment for the covered service.

The method by which a *provider* is paid may change at the time of contract renewal. Methods also vary by *provider*. To get current information about a specific *provider,* contact Sanford Health Plan.

Sanford Health Plan
Member Service
(605) 328-6800 or 1-800-752-5863
For hearing impaired *members:* TTY (605) 328-6869

N. General Provisions

Records.

Providing information. By accepting coverage under this Policy, you authorize any health care *provider* that has examined or treated you to release any information concerning you to Sanford Health Plan. You also authorize Sanford Health Plan to release any information received or maintained by Sanford Health Plan or its health care *providers* to third parties where such release is reasonably necessary for plan administration, *claims* processing, utilization review, quality assessment, case management, medical research and other administrative functions. By accepting coverage under this Policy you authorize the release of such information and waive any claim of privilege or confidentiality with respect to the information when released or obtained for the purposes described in this paragraph. The confidentiality of such information will be maintained by Sanford Health Plan in accordance with existing law.

Clerical Error.

You will not be deprived of coverage under this Policy because of a clerical error. On the other hand, you will not be eligible for coverage beyond the scheduled termination of your coverage because of a failure to record the termination.

Relationship Between Parties.

The relationships between Sanford Health Plan and *Sanford SELECT contracted providers* are contractual relationships between independent contractors. *Sanford Health Plan contracted providers* are not agents or employees of Sanford Health Plan. The relationship between a *provider* and any *member* is that of health care *provider* and patient. Sanford Health Plan has responsibilities assigned to and required of Sanford Health Plan by state and federal requirements, and the *Sanford SELECT contracted provider* is responsible for the services provided by it to any *member*.

Assignment.

Sanford Health Plan will have the right to assign any and all of its rights and responsibilities under this Policy to any subsidiary or affiliate of Sanford Health Plan or to any other appropriate organization or entity. You shall not assign or otherwise transfer your rights or obligations under this Policy, except with the prior written consent of Sanford Health Plan.

Entire Agreement.

This Policy, as amended, is the entire contract between you and Sanford Health Plan, and replaces all other agreements as of the effective date.

Quality Assurance.

When you purchase a Sanford Health Plan Medicare SELECT policy, you agree to use *Sanford SELECT contracted providers* for inpatient

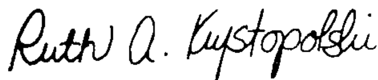
hospital or outpatient surgery center services whenever possible. Sanford Health Plan ensures high quality healthcare through our Quality Improvement Program. Our Quality Improvement Program allows us to provide accountability for the quality of health care delivery and service. We have a committed Board of Directors and Medical Management Quality and the Health Plan Quality Improvement Committees who develop and carry out a Quality Assurance Plan that has a systematic approach to assessing, measuring, defining and resolving medical care, and behavioral health and service issues.

Amendment. Sanford Health Plan may change or amend this Policy upon 30 calendar days written notice to you, provided applicable regulatory approval has been obtained, or when required by federal or state regulatory agencies. When this happens, you will receive a new Policy or amendment. No person or entity has authority to make any other changes or amendments to this Policy.

Discretionary Authority. Sanford Health Plan has discretion to interpret and construe all of the terms and conditions of this Policy and make determinations regarding *benefits* and coverage under this Policy.

Authority. No agent, employee or representative of ours has authority to change this policy or waive any of its provisions. No change in this policy shall be valid until approved by an executive office of the company and unless such approval be endorsed hereon or attached hereto. Unless the change in benefits is required by law, your acceptance of an amendment must be in writing if the amendment reduces or eliminates benefits or increases benefits accompanied by an increase in premium during the policy term.

IN WITNESS WHEREOF, our President and Director hereby sign your contract.



Ruth A. Krystopolski
Vice President Managed Care Services

Lisa M. Carlson
Director of Government Programs