2017

Annual Provider Notice

SANFORD®
HEALTH PLAN

Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110
Ph: (605) 328-6868
1-877-305-6868
Fx: (605) 328-6811
sanfordhealthplan.com

Important Information for Providers about Sanford Health Plan

Sanford Health Plan asks that you take a few minutes to review this information. The following annual notices are provided to keep you well informed of the provisions of the Plan. If you have any questions regarding this information, please feel free to call us at (605) 328-6868 or toll free at (877) 305-5463.

Where can I find important plan information?
Important plan information and the Provider Manual can be found on our website www.sanfordhealthplan.com/providerlogin.You can also obtain copies of the manual by calling our Provider Relations Department toll-free at (800) 601-5086. The Provider Manual and the Provider Perspective newsletter on our website contain information on Plan policies and procedures that are pertinent to participating practitioners. Below is a summary of the information you can find on the mySanfordHealthPlan web portal. Please visit these sites frequently for updates.

Sanford Health Plan's Provider Webpage

Visit sanfordhealthplan.com/providerlogin to find the following:

- Preventive Health Guidelines
- Prior Authorizations: How to prior authorize and what needs prior authorizations
- Pharmacy Benefits/Formulary Information
- Product Fact Sheets & FAQs
- Provider Manual
- Provider Newsletters & Annual Notices
- Provider Directory: Multiple search functions
- Contracting and Credentialing Information
- Electronic Data Interchange Information
- Forms
- Webinar Listings and other Education
- Clinical Resources & Tools, including Clinical Practice Guidelines and many other resources
- Health Management Programs and Quality Improvement Activities; HEDIS® Report

Create a mySanfordHealthPlan Account

Sanford Health Plan's online portal allows practitioners the ability to verify member eligibility, check claim status, view and retrieve explanation of payments and view & submit prior authorization information. To request a mySanfordHealthPlan account, follow the steps below:

1. Go to sanfordhealthplan.com/providerlogin
2. Click "create Provider Account" on the right side of the page
3. When all the required account information has been added, click on "Finish"

Your information will then be submitted for review and approval. Once your account has been approved, you will receive a confirmation email from us. You will then be able to log on to mySanfordHealthPlan using the User ID and Password you created upon setting up the account. If you have any questions or comments, please contact the Provider Relations Department at (605) 328-6877 or (800) 601-5086.

2016 Quality Improvement Progress Report*

Sanford Health Plan and its participating providers are committed to providing high quality health care to our members. The following is a list of the Plan's current quality programs designed to make sure members get the right care, at the right time and the right place. For more information on the Health Plan's QI program and outcomes, see our HEDIS® 2016 Report and the Quality Improvement Program summary, both are located on the Plan's website at sanfordhealthplan.com/memberlogin. You may also call the Health Plan to request a copy of either of these documents at (888) 315-0884. For information on our care management programs listed below and how to enroll, call (888) 315-0884 or visit our website at sanfordhealthplan.com/memberlogin.

Clinical Areas of Quality Improvement

Diabetes
The diabetes health management program provides educational materials and other resources which help members better manage their condition. This program provides the following services to members who enroll:

- Glucometer (upon request)
- Diabetes toolkit
- Four newsletters each year with the most current tips on taking care of diabetes
- Support from our nurses and health care staff as needed
- Members at high risk for health problems will get extra information and contact from nurses

Heart Disease (Coronary Artery Disease)
This program was just implemented July 1, 2015.
The Heart Disease health management program includes educational materials and other resources to help members better manage their condition. This program provides the following services to members who enroll:

- Heart disease toolkit
- Four newsletters each year with the most current tips on heart health
- Support from our nurses and other health care staff as needed
- Members at high risk for health problems will get extra information and contact from nurses

Heart Failure (HF)
The heart failure health management program provides the following services to members who enroll in the program:

- Heart failure toolkit
- Four newsletters each year with the most current tips on managing heart failure
- Support from our nurses and other health care staff as needed
- Members at high risk for health problems will get extra information and contact from nurses

Hypertension
The Healthy Heart health management program provides the following services to members who enroll in the program:

- High blood pressure toolkit
- Four newsletters each year with the most current tips on managing blood pressure
- Support from our nurses and other health care staff as needed
- Members at high risk for health problems will get extra information and contact from nurses

Healthy Pregnancy
Sanford Health Plan provides maternity care benefits from prenatal through postpartum care. The main objective of the program is to assist a member in identifying early concerns so she and her health care provider can take steps to prevent or minimize any problems and ensure a healthy pregnancy. Pregnant members are encouraged to join the Healthy Pregnancy Program during their first trimester of pregnancy. Members who enrolled enjoyed the following benefits:

- A health assessment is available for members that allows the Plan to identify any individual needs and to provide educational information specific to those needs.
- Personal phone calls from a care management nurse as needed.
- Educational materials.

Asthma
The Asthma health management program provides the following services to members who enroll in the program:

- Asthma toolkit
- Four newsletters each year with the most current tips on managing asthma
- Support from our nurses and other health care staff as needed
- Members at high risk for health problems will get extra information and contact from nurses

Behavioral health and substance use disorders
The Plan's activities to improve follow-up after inpatient treatment for behavioral health and/or substance use disorder discharges, and compliance with antidepressant medications, included:

- Letters sent on a monthly basis to members new on antidepressants who have not yet filled their first refill - education included side effects, compliance, etc. Continued to incorporate depression education/resources into other health management programs.
- The Worksite Wellness Life Advocates are making several member referrals to employer groups who participate in the Plan's EAPs.
- Practitioners notified of the recommended clinical practice guidelines for depression through the provider newsletter and on our website.
- The Timeliness of Care Survey was completed and included an assessment of a sample of clinics primarily treating behavioral health and substance use disorders, and their compliance with the Plan's access standards for behavioral health, including behavioral health and substance use disorder, appointments. Clinics included in the survey were sent a follow-up letter to notify them of their compliance or noncompliance and what those standards are.
- The Plan's Life Advocates work with the hospital's discharge planners to arrange a follow-up appointment within seven days of discharge.
- Member Messenger included articles on managing chronic health conditions.
- To increase awareness of available behavioral health and substance use disorder treatment services,
- Quick Reference Behavioral Health Cards were updated and made available on the website to primary care practitioners to assist in locating Sanford Health Plan participating behavioral health and substance use disorder practitioners in their area.
- The Plan also collaborates with behavioral health and substance use disorder treatment professionals to ensure the appropriateness of our activities involving behavioral health and/or substance use disorders.

Attention Deficit/Hyperactivity Disorder (ADD/ADHD)
The ADHD activity focuses on improving the rates of appropriate follow-up for members prescribed ADHD medications:

- Newly identified members with ADHD are sent a postcard that offers a toolkit with education on the symptoms, treatment and follow-up recommendations for patients taking ADHD medications.
- Practitioners are notified of the recommended clinical practice guidelines for ADHD through the provider newsletter and on our website. Tools are also available for practitioners on the website. Practitioners also notified of the information available on the website via the provider newsletter.
- Quick Reference Behavior Health cards were updated and made available via the Plan's website.

Adolescent health
Our adolescents and their parents/guardians educational information about the importance of wellness visits and staying up to date on immunizations. Examples include:

- Birthday card is sent monthly to those members turning 11 and 12 as a reminder to make sure they are up-to-date on immunizations by their 13th birthday and to remind them to get an annual wellness exam.
- The Plan's website contains a KidsHealth website link to a great deal of educational information for kids and parents.
- Immunization schedule is available on the Plan's website.
- The Member Messenger newsletter included an article on adolescent wellness visits and their benefit versus a sports physical. There was also an article on HPV and meningococcal vaccine recommendations.
- In addition, practitioners are notified of Clinical Practice Guidelines in the Provider Perspective newsletter.

Cancer screening
The cancer screening activities focuses on improving the rates of screening for breast cancer, cervical cancer and colorectal cancer. The following are activities completed to improve these rates:

- Preventive Health Guidelines are updated and printed annually in the member newsletter and are available at sanfordhealthplan.com.
- Birthday cards are sent to women turning 21, 40, 50 and 60 and men turning 40, 50 and 60 to remind them of important screening tests (like mammogram, Pap smear, colonoscopy, etc.) and the Plan's benefits for those tests.
- Additional mammogram reminder mailings sent to those members who are 3 months past their 40th birthday.
- A colorectal cancer screening reminder postcard was sent to members
- Practitioners are notified of the recommended clinical practice guidelines for cancer screening through the provider newsletter and on our website.
- With the implementation of Sanford Health's electronic medical record system, OneChart, the health maintenance screen helps to remind physicians of those patients who are due for screening tests.
- The member and provider newsletters contained various newsletter articles regarding cancer screening tests and the Plan's benefits.
- The member and provider newsletters contained various newsletter articles regarding cancer screening tests and the Plan's benefits.
- Preventive screenings are addressed by the nurse case managers in private conversations with members, when applicable.
- Email reminder to age specific members regarding cancer screenings.

Tobacco cessation
The following activities were offered to promote tobacco cessation among the Plan's membership:

- The Plan covers tobacco cessation counseling and medications as part of the preventive benefits.
- All Sanford Health Plan Health Management Programs and other quality improvement activities and member newsletters stress the importance of smoking cessation, the many resources available to our members to help them quit, and the Plan's tobacco cessation benefit information.
- Care management nurses discuss tobacco use with members and also assist in coordinating resources for tobacco cessation.
- Smoking cessation information included in the Member Messenger newsletter.
- Sanford Health Plan's Wellness Educators are certified as health and wellness coaches. They can lead tobacco cessation classes upon request from clients. The educators are continuing to provide one-on-one counseling with members as needed.
- Tobacco cessation web pages were added to the member and provider pages of the website and include education and resources (for adults and kids).
- Practitioners are notified of the recommended clinical guidelines for tobacco cessation through the provider newsletter and on our website.

Non-Clinical Areas of Quality Improvement

CAHPS® Member Satisfaction Survey
The Plan's member satisfaction survey takes place on a yearly basis. This survey is conducted by an independent survey vendor and provides information on the experiences of our members with our Health Plan and how well we meet our members' expectations. There are four overall ratings of satisfaction in addition to seven more focused composite scores which summarize survey responses in key areas. The Plan's QI Committee analyzes the results and takes actions for improvement. For more information on the Plan's CAHPS® rates, refer to our HEDIS® 2016 Report as referenced at the beginning of this article.

Customer services phone calls
This activity involves ongoing monitoring of the Customer Services Department phone call statistics including calls answered, abandoned calls, and average answer speed of calls. Additional training and staff meetings are held to improve these rates and representatives are shown their individual statistics to help them improve their personal performance. Additional staff has been added to address the increasing volume of calls over time and to improve performance in these rates.

Timeliness of Care
This project monitors the appointment access to the Plan's participating practitioners. Phone calls are made to a random sample of clinics to determine their compliance with the Plan's standards for access. All clinics receive a copy of their results and a list of the Plan's access standards. Clinics who did not meet the standards were asked to develop an action plan to assist them in meeting the Plan's appointment access standards.

** HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA). HEDIS® results do not include elite1 individual plan membership data.*

**CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ). CAHPS® results also do not include elite1 individual plan membership data.*

Special communication services
In compliance with the ADA and §508 of The Rehabilitation Act, we have this notice in other formats. Please call us if you need help understanding information at (800) 752-5863 at (toll-free). We can read items to you over the phone and we offer free oral translation in any language through our translation services.

Translation services
We can arrange for translation services. Free written materials are available in many different languages and free oral translation services are available. Call Member Services toll-free (800) 752-5863 for help and to access translation services.

- **Spanish (Español):** Para obtener asistencia en Español, llame al (800) 892-0675 (toll-free).
- **Tagalog (Tagalog):** Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 892-0675 (toll-free).
- **Chinese: (中文):** 如果需要中文的帮助，请拨打这个号码 (800) 892-0675 (toll-free).
- **Navajo (Dine):** Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 892-0675 (toll-free).

Services for the deaf, hearing impaired, and/or visually impaired
If you are deaf or hearing-impaired, and need to speak to us, call TTY/TDD: (877) 652-1844 (toll-free). Please contact us toll-free at (800) 752-5863 if you are in need of a large print copy or cassette/CD of this notice or any other plan document.

Complex Case Management Referral Guide

What is the Complex Case Management Program?
Complex case management (CCM) is the coordination of care and services provided to members who have experienced a critical event or diagnosis that requires the extensive use of resources and who need help navigating the system to facilitate appropriate delivery of care and services. The goal of complex case management is to assist members in regaining optimum health or improved functional capability by monitoring their care to ensure it follows evidence based clinical standards to promote care gap closure, appropriate use of health care resources and cost-effectiveness. It involves the comprehensive assessment of the member's condition; determination of available benefits and resources; and development and implementation of a case management plan with performance goals, monitoring and follow-up.

Is there a cost for the program?
Sanford Health Plan's Complex Case Management Program is available to qualifying Health Plan members and their families at no cost.

How does the program work?
A designated case manager is responsible for managing these complex cases to ensure high quality, cost-effective and appropriate utilization of health services. Case managers are registered nurses who act as member advocates, seeking and coordinating creative solutions to health care needs without compromising quality health outcomes for selected medical diagnoses. The case manager contacts our members by phone and mail and acts as a resource, educator and coordinator of medical care.

What qualifies a member for the program?
Concentrating for the most part on catastrophic or chronic cases, case managers consult and manage:

- Multiple chronic illnesses (e.g., diabetes and cardiovascular problems) and/or chronic illnesses resulting in high utilization
- Individuals with physical or developmental disabilities, serious and persistent mental illness, or severe injuries
- High risk or complicated medical conditions (i.e., transplants, spinal cord injuries, cancer)
- Multiple re-admissions
- Individuals identified from predictive modeling reports based on high cost, likelihood of hospitalization, projected total risk, etc.

How do I refer a Sanford Health Plan member for the program?
If you would like more information about CCM, or if you would like to refer a qualified Sanford Health Plan member for the program, please contact our Care Management Department at (888) 315-0884 or by email at quality@sanfordhealth.org.

- If you are a Sanford practitioner, please feel free to use in basket messaging to contact a Health Plan case manager.
- If a Health Plan case manager is currently following a member, the case manager will be listed on the patient care team in One Chart.
- You can also send an in basket message to "SHP CRM CT Case Management" if you are unable to determine the assigned case manager.

Utilization Management Criteria

Every year, the Plan's Physician Quality Committee reviews the Plan's medical policies and procedures, quality programs and clinical practice guidelines. The Physician Quality Committee is charged with supporting the Plan's Board of Directors and Vice President Medical Director in meeting quality assurance goals on issues of care.

The Committee consists of physician members from various specialties, including a behavioral health practitioner, and meets at least six times a year. The Plan's Vice President Medical Director reports on the Committee's activities to the Board of Directors on a quarterly basis. The Committee is actively involved in the development of quality initiatives and health management programs. It is also responsible for approving and annually reviewing utilization management criteria. Any recommended changes in the criteria or any other program changes are approved by the Board of Directors.

The Pharmacy and Therapeutics Committee is charged with supporting the Plan's Board of Directors and Vice President, Medical Officer in meeting quality assurance goals on pharmaceutical coverage. The Committee membership consists of physicians and pharmacists representing retail and hospital-based pharmacies. Specific specialty physicians are also invited to attend meetings per drug topic or disease managed state reviewed if current Committee membership does not support the topic up for review. The Pharmacy Benefit Manager (PBM) has an assigned Clinical Pharmacist that actively participates in all aspects of Formulary development, ongoing management and resource management. Sanford Health Plan employs clinical pharmacists to assist in the day-to-day management of the pharmacy program. No incentives are given to providers or pharmacists for using specific drugs. Sanford Health Plan currently does have some mandated generic substitution programs in place in their pharmacy benefit program, as well as some step-therapy protocols for multiple drug categories.

All practitioners are welcome to have input into the activities of both committees. Suggestions concerning quality programs, health management programs, clinical practice guidelines and utilization management criteria are welcome and can be directed to the Vice President Medical Director by mail or by phone at (605) 328-6807 or (800) 805-7938.

You may request a copy of the criteria used by contacting the Utilization Management Department or the Vice President, Medical Director.

Clinical Practice Guidelines

Sanford Health Plan is responsible for adopting and distributing clinical practice guidelines for acute, chronic and behavioral health care services that are relevant to our membership. The Plan's multi-specialty physician committee, the Physician Quality Committee, has reviewed and approved practice guidelines for numerous conditions for use as the Plan's primary clinical practice guidelines.

Please visit our website at sanfordhealthplan.com/providerlogin to find links to the adopted guidelines. If you have any questions or suggestions regarding these guidelines, or to request a copy of the guidelines, please call the Plan at (605) 328-6877 or (800) 601-5086.

Preventive Health Guidelines

Sanford Health Plan recognizes that health promotion and disease prevention are the best opportunities to reduce the ever increasing portion of resources spent to treat preventable illnesses and impairments. As a Plan, we want to educate our members on how to cut health care costs, prevent premature onset of disease and disability, and to help all members achieve healthier and more productive lives.

Preventive Health Guidelines are age-specific. They describe prevention or early detection interventions, recommendations for frequency and conditions under which the interventions are required. Appropriate practitioners are involved in the development of preventive health guidelines (i.e., practitioners who are from specialties that would use the guidelines).

Members of Sanford Health Plan are encouraged to utilize preventive health services, health education and health promotion through preventive health services, educational classes and other articles on prevention in special mailings or in the Member Messenger newsletters.

Current Preventive Health Guidelines are available on our website at sanfordhealthplan.com/providerlogin for both members and practitioners (the practitioner version includes the codes that are to be used for these preventive services). A paper copy is available by calling the Plan at (605) 328-6800 or (800) 752-5863.

Physician or Pharmacist reviewer availability:
A physician or pharmacist reviewer is available by phone to any practitioner to discuss determinations based on medical appropriateness from 8 a.m. and 5 p.m., CT, Monday through Friday at (605) 328-6807 or (800) 805-7938.

Utilization Management

Utilization Management (UM) decision-making is based only on appropriateness of care and service and existence of coverage. Sanford Health Plan does not specifically reward practitioners or other individuals conducting utilization review for issuing denials of coverage or service care. Any financial incentives offered to UM decision makers do not encourage decisions that result in under-utilization and do not encourage denials of coverage or service. Decision makers sign an "Affirmative Statement Regarding Incentives" verifying the above conditions.

The Utilization Management Department performs three primary functions: utilization review (prospective or pre-service review, concurrent review, retrospective or post-service reviews), case management and discharge planning.

For information on how to obtain language assistance to discuss Utilization Management issues, please see the Special Communication Services section on page 6.

Utilization review
Utilization review is the process of monitoring and evaluating the medical necessity, appropriateness, and efficacy of health care services and procedures; as well as having the services at appropriate facilities. There are three types of utilization reviews:

- Prospective review (pre-service prior authorization)
- Concurrent review
- Retrospective (post-service) review.

Reviews are subject to specific decision and notification time standards; per state and federal laws, and NCQA (National Committee for Quality Assurance) standards.The Utilization Management Department will review member profile information against standard criteria. Determinations and notifications of decisions to the member and practitioner and/or provider are made by the Utilization Management Department within the timeframes required by state law and NCQA standards. Certain circumstances may allow for an extension, for example, due to lack of necessary information to make the determination. Sanford Health Plan's procedure is in the Provider Portal that deals with timely handling of review requests and for details on extensions for special circumstances. For more information, visit the Member Rights section at sanfordhealthplan.com or contact Provider Relations or Utilization Management Departments.

The Utilization Management Department is available between the business hours of 8 a.m. to 5 p.m., CT, Monday through Friday (excluding holidays.) practitioners, providers and members may call the Plan's toll-free number (800) 805-7938 | TTY/TDD: (877) 652-1844 (toll-free). After business hours, you may leave a confidential voicemail and someone will return your call on the next business day. The Utilization Management fax number is (605) 328-6813.

For North Dakota Public Employees Retirement System (NDPERS), the Utilization Management Department is available between the business hours of 8 a.m. to 5 p.m. Central Time, Monday through Friday (excluding holidays).

Practitioners, Providers and Members may call the Plan's toll-free number
(888) 315-0885 | TTY/TDD: (877) 652-1844 (toll-free). After business hours, you may leave a confidential voicemail and someone will return your call on the next business day. The Utilization Management fax number is (701) 234-4547.

Prior authorization/certification
Prior authorization (certification or precertification) is the urgent or non-urgent authorization of a requested service prior to receiving the service. The approval for prior authorization is based on appropriateness of care and service and existence of coverage.

Points to remember

- The member is ultimately responsible for obtaining prior authorization from the Utilization Management Department in order to receive in-network coverage. However, information provided by your office will also satisfy this requirement.
- All requests for certification are to be made by the member or their practitioner's office at least three (3) working days prior to the scheduled admission or requested service. In the event that health care services need to be provided within less than three (3) working days, contact the Utilization Management Department to request an expedited review.
- All referrals to non-participating providers (at the recommendation of a participating provider) require prior authorization.

How to request prior authorization
Prior authorizations for health care services can be obtained by contacting the Utilization Management Department online, by phone or fax:

- Phone: (800) 805-7938 and follow the appropriate menu prompts. Team members are available to take your calls from 8 a.m. to 5 p.m., CT, Monday through Friday. After hours you may leave a message on the confidential voice mail and someone will return your call the following business day.
- Fax: Please fax the prior authorization form and supporting documentation to (605) 328-6813. Please fax the prior authorization form and supporting documentation for NDPERS members to (701) 234-4547.
- Online: Select "Submit/Request/Report" under "Provider Inquiries" on your secure mySanfordHealthPlan account at sanfordhealthplan.com/providerlogin. Click on "Submit a preauthorization/precertification." Once you complete the required information click "Submit."

Services requiring prior authorization
Admission before the day of non-emergency surgery will not be covered unless the early admission is medically necessary and specifically approved by Sanford Health Plan. Coverage for hospital expenses prior to the day of surgery at an out-of-network facility will be denied unless authorized prior to being incurred.

The following services require prior authorization:

Ambulance Services
Includes:
- Air Ambulance Services
- Non-emergent transportation

Admissions
Includes:
- Inpatient Medical, Surgical, Behavioral Health or Chemical Dependency
- Inpatient Rehabilitation
- Long Term Acute Care
- Residential Treatment
- Skilled Nursing Facility
- Swing Beds

Clinical Trials
Includes:
- All clinical trials

Durable Medical Equipment
Includes, but is not limited to:
- Airway Clearance Device
- Communication Device
- Continuous Glucose Monitors and Sensors
- Cranial Molding Helmet
- Dental Appliances
- Home INR Monitor
- Hospital or Specialty Beds
- Insulin Pump
- Selected Orthotics
- Phototherapy UVB Light Device
- Pneumatic Compression with external pump
- Power Wheelchair and Scooter
- Prosthetic Limb

Home Health/ Hospice Services
Includes:
- Home Health Services
- Home Infusion (IV) Services
- Hospice Services

Implants/Stimulators
Includes:
- Bone Growth (external)
- Cochlear Implant (Device and Procedure)
- Deep Brain Stimulation
- Gastric Stimulator
- Spinal Cord Stimulator (Device and Procedure)
- Vagus Nerve Stimulator

Oncology Services and Treatment
Includes:
- Includes all chemotherapy and radiation therapy as part of an oncology treatment plan

Outpatient Services
Includes but is not limited to:
- Alopecia treatment
- Applied Behavioral Analysis (ABA)
- Biofeedback
- Botox
- Brachytherapy
- Chelation Therapy
- Dental Anesthesia
- Genetic Testing
- Home Sleep Study
- Hyperbaric Oxygen Therapy
- Infertility Treatment
- Medical Nutrition
- Orthodontia
- Neuromuscular Electrical Stimulation
- Photodynamic Therapy
- Platelet Rich Plasma (PRP)
- Radiofrequency Ablation
- Varicose Vein Treatment

Outpatient Surgery
Includes but is not limited to:
- Abdominoplasty or Panniculectomy
- Bariatric Surgery
- Blepharoplasty
- Breast Implant Removal, Revision or Re-implantation
- Breast Reconstructive and Mastectomy
- Endoscopic Sinus Surgery
    - Intrathecal Pain Pump
    - Mammoplasty
    - Orthognatic Procedures
    - Rhinoplasty
    - Septoplasty
    - Spine Surgery
    - Temporomandibular Joint (TMJ)

Specialty Drugs and Selected Injectables
See the Sanford Health Plan Formulary for drug prior authorization requirements

Spine Surgery
Includes:
- All inpatient and outpatient spine surgery

Transplants
Includes:
- Transplant evaluation
- All tansplant services including artificial pancreas

Additional services requiring prior authorization for Simplicity and TRUE members
The services listed above still apply to Simplicity and TRUE members. These plans offer pediatric dental coverage. Therefore, the following procedures require prior-authorization:

- Medically-Necessary Dental Implants for Children Age 0-18 Years**
- Medically-Necessary Orthodontics for Children Age 0-18 Years

***Other periodontic and endodontic procedures do not require prior authorization.*

For complete prior authorization information, please refer to the member plan document.
Refer to the SHP pharmacy handbook and formulary for medications requiring prior authorization.

Additional services requiring prior authorization for Bethany Retirement Living members
The listing below is a complete listing for Bethany Retirement Living members.

- Inpatient Hospitalizations at Out-of-Network Facilities (includes Out-of-Network inpatient non-emergency (planned) admissions for medical and/or surgical reasons; and non-emergency (planned) admissions for treatment of a mental health and/or substance use disorder);
- Residential Treatment Facility admissions; and
- Skilled Nursing Facility Admissions (In-and Out-of-Network);
- Long Term Acute Care Facility Admissions (In-and Out-of-Network);
- Transitional Care Unit Admissions (In-and Out-of-Network);
- Home Health, Hospice, and Home IV therapy services (In-and Out-of-Network);
- Infertility Services, including assisted reproductive technology for GIFT, ZIFT, ICSI and IVF (In-and Out-of-Network); and
- Genetic Testing (In-and Out-of-Network).

New medical technologies/new applications for existing technologies, experimental/investigational procedures

In order to ensure members access to safe and effective care, Sanford Health Plan has adopted a formal mechanism to evaluate and address new developments and new technology in medical and behavioral health procedures, pharmaceuticals and devices.

The Physician Quality Committee is responsible to recognize and evaluate new health care services, medical and behavioral health procedures, pharmacological treatments and devices as well as their application for the Health Plan members. The Physician Quality Committee includes a practitioner who specializes in behavioral healthcare in this decision making process.

A specialist representing the new technology (i.e. physician, pharmacist, etc.), if not a member of the Committee, may be invited to present the technological aspects of the service/procedure/pharmacological treatment, as needed.

Published scientific evidence and information from literature and the Internet will be reviewed to make the appropriate decisions. The technology must have final approval from appropriate government regulatory bodies. Investigational and experimental treatments/medications will not be approved for usage under the Sanford Health Plan Benefits Policy guidelines.

To be eligible for consideration of coverage all of the following must be met:

1. The technology must have final approval from appropriate government regulatory bodies (i.e. FDA).
2. The published scientific evidence must permit conclusions concerning the effect of the technology on health outcomes. (Literature, Internet or Specialist review)
3. The technology must improve net health outcomes.
4. The technology must be at least as beneficial as all established alternatives.
5. The health benefit must be attainable outside an investigative setting.
6. External healthcare experts utilized in the review process shall include licensed or qualified healthcare professional in the field of study or treatment for which the experimental treatment review is taking place. (i.e. licensed chiropractors will review experimental/investigative treatments in the area of chiropractic care.)

This review will start with the completion and submission of an application that will be reviewed for medical content and prioritization. This process will consider factors such as medical impact, safety, efficacy, clinical trial phase and cost-to-benefit ratios. After submitting the application, it may take several months to be incorporated into a covered benefit option.

The completion of the application packet does not guarantee coverage of benefits, and the request must be completed prior to claim submission of the new product or service.

The next step is the determination of coverage or a denial. This step will be a review by many departments in the Health Plan. Once the coverage options are discovered, it will move onto a Physician Quality Committee Review. Once the new technology or new application of an existing technology has been reviewed by the

Physician Quality Committee, this review can result in either of two types of decisions:

1. A policy determination to include a new technology as a covered benefit in the future. The Medical Management policy that uses the MCG (Milliman Care Guidelines) criteria will be developed by the Medical Management staff and will be presented at the same time. This would become the policy for this new health care service, medical and behavioral health procedure, pharmacological treatment or device.
2. A case-based decision on whether or not to cover a specifically requested service. There must be evidence that case-based decisions result in a review of medical necessity guidelines and procedures for possible revision.

Upon approval from the Board of Directors, Sanford Health Plan will notify its Members and Practitioners by way of the newsletter, if appropriate.

The Vice President Medical Director and the Physician Quality Committee will consider all requests for coverage based on the Benefits Policy guidelines. If you would like more information on either of these policies, please contact our Customer Services Department at (605) 328-6800 or (800) 752-5863.

Formulary statement

The Sanford Health Plan Formulary is a list of FDA approved brand-name and generic medications chosen by health care providers on the Pharmacy and Therapeutics (P&T) Committee. Selection criteria include clinical efficacy, safety, and cost effectiveness. Changes are made throughout the year as warranted, with a complete review performed each year. For a complete listing of the formulary, pharmacy locator, generic substitution information, medication side effect and interaction information, and other benefit information, log into your secure mySanfordHealthPlan account at sanfordhealthplan.com/memberlogin.

By following the Sanford Health Plan Formulary, and asking your health care practitioner for generic medications when available, you will save money and help control the costs of your health care. If you request a brand-name medication when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic in addition to your copay. When your health care practitioner prescribes a medication for you, you can ask that he or she refer to the Sanford Health Plan Formulary found on their mySanfordHealthPlan provider account at sanfordhealthplan.com/providerlogin.

To be covered by the Plan, medications must be

1. Prescribed by a licensed health care professional within the scope of his or her practice;
2. Listed in the Plan Formulary, unless certification is given by the Plan;
3. Provided by a participating pharmacy except in the event of a medical emergency. If the prescription is obtained at a non-participating pharmacy, the member is responsible for the prescription medication cost in full.
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

Types of Formulary Programs***

2-Tier Formulary
A 2-Tier medication benefit uses a copayment structure to reduce your out-of-pocket costs when using generic or preferred brand name medications. When a prescription is filled, your copayment will be at least one of these tiers: ***

- Tier 1: generic medications
- Tier 2: all covered brand name medications

3-Tier Formulary
A 3-Tier medication benefit uses a copayment structure to reduce your out-of-pocket costs when using generic or preferred brand name medications. When a prescription is filled, your copayment will be at least one of these tiers: ***

- Tier 1: generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications

4-Tier Formulary
A 4-Tier medication benefit uses a copayment structure to reduce your out-of-pocket costs when using generic or preferred brand name medications. When a prescription is filled, your copayment will be at least one of these tiers: ***

- Tier 1: generic medications
- Tier 2: preferred brand name medications
- Tier 3: non-preferred brand name medications
- Tier 4: formulary or specialty name brand medications exceeding a contracted value of $400

5-Tier Formulary
A 5-Tier medication benefit uses a copayment structure to reduce your out-of-pocket costs when using generic or preferred brand name medications. When a prescription is filled, your copayment will be at least one of these tiers: ***

- Tier 1: preferred generic medications
- Tier 2: non-preferred generic medications
- Tier 3: preferred brand name medications
- Tier 4: non-preferred brand name medications
- Tier 5: specialty medications

****The higher the tier, the higher the copay*

A brand name medication is a medication manufactured and marketed under a trademark or name by a specific manufacturer.

A generic medication is a medication that (1) is approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the brand name medication, (2) contains the same active ingredient as the brand name equivalent, and (3) typically costs less than the brand name equivalent.

A specialty medication is a high cost medication which treats complex chronic conditions. These medications are often of biologic origin. The sensitive nature of these medications requires special storage, handling, and administration. Specialty medications are typically only available through select pharmacies equipped to appropriately distribute these medications.

A biosimilar medication is a medication approved by the Food and Drug Administration (FDA) as a similar alternative medication to a specialty medication. This new category of medication was initially defined by the Affordable Care Act, and specific interchange regulations are currently being defined.

Specialty Medication Program

Sanford Health Plan has contracted with Accredo for specialty medications (refer to your Pharmacy Handbook for a list of specialty medications that must be obtained from Accredo). Accredo will ship your medication and all the supplies you need for your medication directly to your home or health care practitioner's office within 24 to 48 hours after the request is approved and medication is ordered. Administration supplies (syringes, needles etc.) are free; you are not required to pay additional copays for those supplies. Prior to all shipments, a Patient Admission Specialist will contact you to discuss the copay for your medication and arrange delivery.

To enroll in the Accredo program, call toll-free at (866) 333-9721 and a customer service representative will ask the following information:

- Your name and date of birth
- Your phone number and address
- The name of your specialty medication to be filled
- Your health care practitioner's name and phone number

Accredo will mail a letter to your health care practitioner explaining the program and how to send your prescription order(s) to Accredo.
By participating in Specialty Care, you are automatically enrolled in a medication therapy management program. This program entitles you to receive the following benefits at no additional charge:

- Access to nurses and pharmacists 24 hours a day, 365 days a year for questions related to your specialty medication and the illness the medication is treating.
- Medication refills reminders if you forget to call for your refill, and a convenient refill process.
- Free delivery of your medication and supplies to your home, practitioner's office, or designated location.

Prior Authorization
Select medications require prior-authorization before coverage. Your health care practitioner must contact the Pharmacy Management Department at (855) 305-5062 to start the prior authorization process (information on this process, including the necessary prior authorization form, is available to the practitioner on their mySanfordHealthPlan provider account at sanfordhealthplan.com/providerlogin).

Step Therapy Program
A program that requires certain medications to be used in a specific order, or by "steps." If you try a "first-step" medication and it does not work for you, or if you experience adverse side effects, then the next step medication may be tried, etc. This program is designed to save you money by trying alternative medications before more expensive medications are used.

Exception to formulary
If your or your health care practitioner feel that a certain medication is medically necessary for your condition, an Exception to the Formulary Process is available (refer to the Exception to the Formulary Process in your Policy). Please note that participating practitioners have been given instructions on how to obtain exceptions to the formulary.

The Plan will use appropriate pharmacists and/or practitioners to consider exception requests and promptly grant an exception to the formulary, including exceptions for anti-psychotic and other behavioral health medications, for you when the health care practitioner prescribing the medication indicates to the Plan that:

1. The formulary medication causes an adverse reaction in the patient;
2. The formulary medication is contraindicated for the patient; or
3. The prescription medication must be dispensed as written to provide maximum medical benefit to the patient.

Note: You must generally try formulary medications before an exception for the formulary will be made for non-formulary medication use. To request an exception to the formulary, please call Pharmacy Management Department at (855) 305-5062.

If you receive an adverse determination to your request for an exception to the formulary, please *follow the Complaints and Appeals Procedure and the External Review Rights* in the Policy. This applies to requests for coverage of non-covered medications, generic substitutions, therapeutic interchanges and step-therapy protocols.

For more detailed pharmacy information
Please refer to the following documents for specific medication coverage information. You received this information upon enrollment, but you may also obtain a copy (1) online at sanfordhealthplan.com/memberlogin or (2) by calling Customer Services at (800) 752-5863.

- Summary of Benefits and Coverage – describes the payments for which you are responsible when purchasing prescription medications and supplies;
- Pharmacy Handbook – describes specific information on medication exclusions, medications that require certification, quantity level limits on medications, the Plan's specialty medication program, and the formulary.
- Policy – describes how and where to obtain your prescription medications and supplies, dispensing limitations, and excluded medications and supplies.

Member Rights & Responsibilities

Important Enrollee Information (Minnesota Only)

The HMO coverage described in this Policy may not cover all your health care expenses. Read this Policy carefully to determine which expenses are covered.

The laws of the State of Minnesota provide Members of an HMO certain legal rights, including the following:

1. COVERED SERVICES. These are network services provided by participating Sanford Health Plan network providers or authorized by those providers. Your Policy fully defines what services are covered and described procedures you must follow to obtain coverage.
2. PROVIDERS. Enrolling with Sanford Health Plan does not guarantee services by a particular provider on the list of network providers. When a provider is no longer part of the Sanford Health Plan network, you must choose amount from remaining Sanford Health Plan network providers.
3. EMERGENCY SERVICES. Emergency services from providers outside the Sanford Health Plan network will be covered only if proper procedures are followed. Read this Policy for the procedure, benefits and limitations associated with emergency care from Sanford Health Plan network and non-Sanford Health Plan network providers.
4. EXCLUSIONS. Certain service or medical supplies are not covered. Read this Policy for a detailed explanation of all exclusions.
5. CANCELLATION. Your coverage may be cancelled by you or Sanford Health Plan only under certain conditions. Read your Policy for the reasons for cancellation of coverage.
6. NEWBORN COVERAGE. A newborn infant is covered from birth. Sanford Health Plan will not automatically know of the newborn's birth or that you would like coverage under this Plan. You should notify Sanford Health Plan of the newborn's birth and that you would like coverage. If your Policy requires an additional payment for each dependent, Sanford Heath Plan is entitled to all enrollment payments due from the time of the infant's birth until the time you notify the Plan of the birth. Sanford Health Plan may withhold payment of any health benefits for the newborn infant until any enrollment payment you owe is paid.
7. PRESCRIPTION DRUGS AND MEDICAL EQUIPMENT. Enrolling with Sanford Health Plan does neither guarantees that any particular prescription drug will be available nor that any particular piece of medical equipment will be available, even if the drug or equipment is available at the start of the Policy year.

ENROLLEE BILL OF RIGHTS (Minnesota)

1. Enrollees have the right to be informed of health problems, and to receive information regarding treatment alternatives and risks which is sufficient to assure informed choice.
2. Enrollees have the right to refuse treatment, and the right to privacy of medical and financial records maintained by the health maintenance organization and its health care providers, in accordance with existing law.
3. Enrollees have the right to file a complaint with the health maintenance organization and the commissioner of health and the right to initiate a legal proceeding when experiencing a problem with the health maintenance organization or its health care providers.
4. Enrollees have the right to a grace period of 31 days for the payment of each premium for an individual health maintenance contract falling due after the first premium during which period the contract shall continue in force.
5. 5Medicare enrollees have the right to voluntarily disenroll from the health maintenance organization and the right not to be requested or encouraged to disenroll except in circumstances specified in federal law.
6. Medicare enrollees have the right to a clear description of nursing home and home care benefits covered by the health maintenance organization.

South Dakota, Iowa, Minnesota and North Dakota Individual and Group Policy Member Rights

The Plan is committed to treating members in a manner that respects their rights. In this regard, the Plan recognizes that each member (or the member's parent, legal guardian or other representative if the member is a minor or incompetent) has the right to the following:

1. Members have the right to receive impartial access to treatment and/or accommodations that are available or medically indicated, regardless of race; ethnicity; gender; gender identity; sexual orientation; medical condition, including current or past history of a mental health and substance use disorder; disability; religious beliefs; national origin; age; or sources of payment for care.
2. Members have the right to considerate, respectful treatment at all times and under all circumstances with recognition of their personal dignity.
3. Members have the right to be interviewed and examined in surroundings designed to assure reasonable visual and auditory privacy.
4. Members have the right, but are not required, to select a Primary Care Physician (PCP) of their choice. If a member is dissatisfied for any reason with the PCP initially chosen, he/she has the right to choose another PCP.
5. Members have the right to expect communications and other records pertaining to their care, including the source of payment for treatment, to be treated as confidential in accordance with the guidelines established in applicable South Dakota, North Dakota, and Iowa law.
6. Members have the right to know the identity and professional status of individuals providing service to them and to know which physician or other practitioner is primarily responsible for their individual care. Members also have the right to receive information about our clinical guidelines and protocols.
7. Members have the right to a candid discussion with the practitioner(s) and/or Provider(s) 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.
8. Members have the right to give informed consent before the start of any procedure or treatment.
9. When Members do not speak or understand the predominant language of the community, the Plan will make its best efforts to access an interpreter. The Plan has the responsibility to make reasonable efforts to access a treatment clinician that is able to communicate with the Member.
10. Members have the right to receive printed materials that describe important information about the Plan in a format that is easy to understand and read.
11. Members have the right to a clear grievance and appeal process for complaints and comments and to have their issues resolved in a timely manner.
12. Members have the right to appeal any decision regarding medical necessity made by the Plan and its practitioners and/or providers.
13. Members have the right to terminate coverage under the Plan, in accordance with applicable Employer and/or Plan guidelines.
14. Members have the right to receive information about the organization, its services, its practitioners and providers and members' rights and responsibilities.
15. Members have the right to make recommendations regarding the organization's Member's rights and responsibilities policies.
16. Members have the right to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, or the use of restraints and seclusion.
17. North Dakota Medicaid Expansion Members have the right to receive at least 30 days' notice prior to any change in benefits.

Member Responsibilities for Minnesota, North Dakota, Iowa, and South Dakota

Each Member (or the member's parent, legal guardian or other representative if the member is a minor or incompetent) is responsible for cooperating with those providing health care services to the member, and shall have the following responsibilities:

1. Members have the responsibility to provide, to the best of their knowledge, accurate and complete information about present complaints, past illnesses, hospitalizations, medications, and other matters relating to their health. They have the responsibility to report unexpected changes in their condition to the responsible practitioner. Members are responsible for verbalizing whether they clearly comprehend a contemplated course of action and what is expected of them.
2. Members are responsible for carrying their Plan ID cards with them, and for having member identification numbers available when telephoning or contacting the Plan, or when seeking health care services.Members are responsible for following all access and availability procedures.
3. Members are responsible for seeking emergency care at a Plan participating emergency facility whenever possible. In the event an ambulance is used, Members are encouraged to direct the ambulance to the nearest participating emergency facility unless the condition is so severe that you must use the nearest emergency facility. State law in North Dakota, Iowa, and South Dakota requires that the ambulance transport you to the hospital of your choice unless that transport puts you at serious risk.
4. Members are responsible for notifying the Plan of an emergency admission as soon as reasonably possible and no later than forty-eight (48) hours (ten (10) days for North Dakota Medicaid Expansion members) after becoming physically or mentally able to give notice.
5. Members are responsible for keeping appointments and, when they are unable to do so for any reason, for notifying the responsible practitioner or the hospital.
6. Members are responsible for following their treatment plan as recommended by the Practitioner primarily responsible for their care. Members are also responsible for participating in developing mutually agreed-upon treatment goals, and to the degree possible, for understanding their health care conditions, including mental health and/or substance use disorders.
7. Members are responsible for their actions if they refuse treatment or do not follow the Practitioner's instructions.
8. Commercial Members are responsible for notifying the Plan through their employer within thirty (30) days if they change their name, address, or telephone number. Medicaid Expansion Members must contact their county Department of Human Services to inform them of a change in status. NDPERS Members are responsible for notifying NDPERS within thirty-one (31) days if they change their name, address, or telephone number. Members are responsible for notifying NDPERS of any changes of eligibility that may affect their membership or access to services. The employer is responsible for notifying the Plan.
9. Commercial Members are responsible for notifying their employer and/or the Plan of any changes of eligibility that may affect their membership or access to services. The employer is responsible for notifying the Plan.