Lewis Drug
Enrollment Guide

JobID: 582848 RP:1 1 / 2028 Section 1 of 28 Sheet: 1 Web Request

Lewis Drug
Enrollment Guide

Health insurance made simple.

Sanford Health Plan welcomes you into our integrated system of care. We know you have a variety of options when it comes to making your health insurance decisions – so thank you for your interest in Sanford Health Plan!

This booklet is designed to provide you with an overview of the plan(s) available and the advantage you receive when choosing Sanford Health Plan for your health insurance needs. You will also find information about accessing the provider network, pharmacy network and more.

If you have questions, we are here to help. Call us at (605) 328-6800 or (800) 752-5863.

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Non-discrimination notice

Sanford Health Plan does not discriminate against any future, current, or past Member on the basis of race; ethnicity; color; national origin; disability; sex; gender; sexual orientation; gender identity; religion; spiritual beliefs; medical condition, including a current or past history of mental health and substance use disorders; sources of payment for care; or age, in its coverage, treatment, or benefit decisions. Sanford Health Plan:

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

If you need these services, contact Customer Service at 1-800-752-5863, 8 a.m. to 5 p.m. Central Time, Monday-Friday.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in any way on the basis of race, color, national origin, age, disability, or sex, contact our Director of Customer Service at 300 Cherapa Place #201, Sioux Falls, SD 57103, (605) 328-6800, TTY Number (877) 652-1844, memberservices@sanfordhealth.org. You can file a grievance in person or by mail, fax, or email.

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

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

Free help in other languages

For help in a language other than English, please call us toll-free at (800) 892-0675. Both oral and written translation services are available for free in at least 150 languages. If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-892-0675 (TTY: 1-877-652-1844).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-892-0675 (TTY: 1-877-652-1844).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-892-0675 (TTY: 1-877-652-1844).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-892-0675 (TTY: 1-877-652-1844).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-892-0675 (TTY: 1-877-652-1844).

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Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-892-0675 (телетайп:1-877-652-1844)

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-892-0675 (TTY: 1-877-652-1844).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-778-256-4481 (رقم هاتف الصم والبكم -1-800-298-5760

Karen: ဟ်သူဉ်ဟ်သး - နမ့ၢ်ကတိၤ ကညီ ကျိာ်, ကျိာ်တၢ်မၤစၢၤ ကလီ ကိးဒ်သိး Sanford Health Plan [Karen text partially illegible] 1-800-892-0675 တက့ၢ်.

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-892-0675 (መስማት ለተሳናቸው:1-877-652-1844).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-892-0675 (TTY: 1-877-652-1844). 번으로 전화해 주십시오.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-892-0675 (ATS: 1-877-652-1844).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-892-0675 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-877-652-1844).

Cambodian, Mon-Khmer: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-892-0675 (TTY: 1-877-652-1844)

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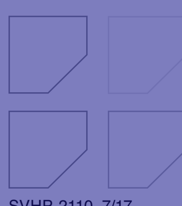
Help understanding this document is free

If you would like this policy in another format (for example, a larger font size of a file for use with assistive technology, like a screen reader),

please call us at: (800) 752-5863 (toll-free) | TTY/TDD: (877) 652-1844

Summary of Benefits & Coverage

SANFORD® HEALTH PLAN



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SANFORD HEALTH PLAN

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Coverage Services

Lewis Drug, Inc. $1,250 | South Dakota

Coverage Period: 1/1/18 to 12/31/18

Coverage for: Individual + Family | Plan Type: HMO | Non-Grandfathered

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to sanfordhealthplan.com/policy/SVHP-0077.pdf or call 1-800-752-5863 (toll-free) | TTY/TDD: 1-877-652-1844 (toll free). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-752-5863 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers $1,250 individual / $2,500 family. For out-of-network providers $2,500 individual / $5,000 family.	Generally, you must pay all the costs from the providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $2,500 individual / $5,000 family. For out-of-network providers $5,000 individual / $10,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.sanfordhealthplan.org or call 1-800-752-5863 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / visit; Deductible does not apply	40% coinsurance	None
	Specialist visit	$30 copay / visit; Deductible does not apply	40% coinsurance	None
	Preventive care / screening / Immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. For details reference the Preventive Health Guidelines or contact Customer Service.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sanfordhealthplan.org	Generic drugs (Tier 1)	$15 copay / prescription; Deductible does not apply	Not Covered	Covers up to a 30 day supply. Some specialty medications may be obtained with a copay depending on where they are received or administered. Refer to your Summary of Pharmacy Benefits / Formulary to determine which benefit applies to your medication. Certain contraceptive drugs covered at 100%.
	Preferred brand drugs (Tier 2)	$35 copay / prescription; Deductible does not apply	Not Covered	
	Non-preferred brand drugs (Tier 3)	$50 copay / prescription; Deductible does not apply	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	These services require certification by the plan for in-network coverage levels to apply.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay / visit; Deductible does not apply	$150 copay / visit; Deductible does not apply	Copay waived if directly admitted. Out-of-network is the same as in-network benefit unless the plan determines the condition did not meet prudent layperson definition of emergency; then the out-of-network deductible and coinsurance applies. Member is responsible for charges above Reasonable Cost of defined by the Policy/Certificate of Insurance.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$30 copay / visit; Deductible does not apply	$30 copay / visit; Deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay / visit; Deductible does not apply and 20% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Inpatient services require certification by the Health Plan for in-network coverage levels to apply. For full details, please refer to your policy.
If you are pregnant	Office visits	$30 copay / visit; Deductible does not apply and 20% coinsurance for other outpatient services	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. Limited to 40 visits per calendar year.
	Rehabilitation services	$30 copay / visit; Deductible does not apply and 20% coinsurance for ancillary services	40% coinsurance	Office Visit includes practitioner consults. Ancillary includes but is not limited to x-rays, labs, ultrasounds, and rehabilitation therapy. Limited to 30 visits per therapy per calendar year.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. Limited to 30 days in any consecutive 12-month period.
	Durable medical equipment	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. For full details, please refer to your Policy/Certificate of Insurance.
	Hospice services	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply.
If your child needs dental or eye care	Children's eye exam	No Charge	40% coinsurance	Covered when part of a preventive exam.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Routine foot care (for diabetics only)
- Telehealth/e-visit/video visit services

Your Right to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for these agencies is: South Dakota Department of Labor at 1-605-773-3101. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sanford Health Plan/Customer Service at 1-800-752-5863 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-857-4426 (toll free).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-857-4426 (toll free).
Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-855-857-4426 (toll free).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-857-4426 (toll free).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $1,250
- Specialist copayment $30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$1,250
Copayments	$0
Coinsurance	$1,250
What isn't covered	
Limits Or Exclusions	$60
The Total Peg Would Pay Is	$2,560

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $1,250
- Specialist copayment $30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits Or Exclusions	$60
The Total Joe Would Pay Is	$1,760

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible $1,250
- Specialist copayment $30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic tests (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	$1,930

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,250
Copayments	$200
Coinsurance	$30
What isn't covered	
Limits Or Exclusions	$0
The Total Mia Would Pay Is	$1,480

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Sanford Wellness at 1-877-305-5463. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

SANFORD HEALTH PLAN

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

If you need these services, contact Sanford Health Plan at 1-800-752-5863, 8 a.m. to 5 p.m. Central Time, Monday-Friday.

If you believe Sanford Health Plan has failed to provide these services or discriminated in any way. Contact our Director of Customer Service and Enrollment, 300 Cherapa Place #201, Sioux Falls, SD 57103, 1-605-328-6800, TTY Number 1-877-652-1844, memberservices@sanfordhealth.org. You can file a grievance in person, by mail, fax, or email.

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

Free help in other languages

For help in a language other than English, please call us toll-free at 1-855-857-4426. Both oral and written translation services are available for free in at least 150 languages. If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us.

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Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-857-4426 (TTY: 1-877-652-1844).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-857-4426 (TTY: 1-877-652-1844).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-857-4426 (TTY: 1-877-652-1844).

Chinese: 注意：如果您使用繁體中文， 您可以免費獲得語言援助服務。請致電 1-855-857-4426 (TTY: 1-877-652-1844).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-857-4426 (TTY: 1-877-652-1844).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-857-4426 (телетайп: 1-877-652-1844)

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-857-4426 (TTY: 1-877-652-1844).

Arabic: ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-857-4426 (رقم هاتف الصم والبكم 1-877-652-1844).

Karen:

[illegible] Sanford Health Plan [illegible] 1-855-857-4426 [illegible]

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-857-4426 (መስማት ለተሳናቸው: 1-877-652-1844).

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Cambodian, Mon-Khmer:
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-857-4426 (TTY: 1-877-652-1844)

Help understanding this document is free

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SANFORD HEALTH PLAN

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Coverage Services
Lewis Drug, Inc. $2,500 | South Dakota

Coverage Period: 1/1/18 to 12/31/18
Coverage for: Individual + Family | Plan Type: HMO | Non-Grandfathered

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to sanfordhealthplan.com/policy/SVHP-0077.pdf or call 1-800-752-5863 (toll-free) | TTY/TDD: 1-877-652-1844 (toll free). For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-752-5863 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers $2,500 individual / $5,000 family. For out-of-network providers $3,750 individual / $7,500 family.	Generally, you must pay all the costs from the providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $3,750 individual / $7,500 family. For out-of-network providers $5,625 individual / $11,250 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.sanfordhealthplan.org or call 1-800-752-5863 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / visit; Deductible does not apply	40% coinsurance	None
	Specialist visit	$30 copay / visit; Deductible does not apply	40% coinsurance	None
	Preventive care / screening / Immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. For details reference the Preventive Health Guidelines or contact Customer Service.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sanfordhealthplan.org	Generic drugs (Tier 1)	$15 copay / prescription; Deductible does not apply	Not Covered	Covers up to a 30 day supply. Some specialty medications may be obtained with a copay depending on where they are received or administered. Refer to your Summary of Pharmacy Benefits / Formulary to determine which benefit applies to your medication. Certain contraceptive drugs covered at 100%.
	Preferred brand drugs (Tier 2)	$35 copay / prescription; Deductible does not apply	Not Covered	
	Non-preferred brand drugs (Tier 3)	$50 copay / prescription; Deductible does not apply	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	

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Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	These services require certification by the plan for in-network coverage levels to apply.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay / visit; Deductible does not apply	$150 copay / visit; Deductible does not apply	Copay waived if directly admitted. Out-of-network is the same as in-network benefit unless the plan determines the condition did not meet prudent layperson definition of emergency; then the out-of-network deductible and coinsurance applies. Member is responsible for charges above Reasonable Cost of defined by the Policy/Certificate of Insurance.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$30 copay / visit; Deductible does not apply	$30 copay / visit; Deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay / visit; Deductible does not apply and 20% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Inpatient services require certification by the Health Plan for in-network coverage levels to apply. For full details, please refer to your policy.
If you are pregnant	Office visits	$30 copay / visit; Deductible does not apply and 20% coinsurance for other outpatient services	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. Limited to 40 visits per calendar year.
	Rehabilitation services	$30 copay / visit; Deductible does not apply and 20% coinsurance for ancillary services	40% coinsurance	Office Visit includes practitioner consults. Ancillary includes but is not limited to x-rays, labs, ultrasounds, and rehabilitation therapy. Limited to 30 visits per therapy per calendar year.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. Limited to 30 days in any consecutive 12-month period.
	Durable medical equipment	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. For full details, please refer to your Policy/Certificate of Insurance.
	Hospice services	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply.
If your child needs dental or eye care	Children's eye exam	No Charge	40% coinsurance	Covered when part of a preventive exam.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Cosmetic Surgery
- Dental care (Adult)
- Hearing Aids
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private Duty Nursing
- Routine eye care (Adult)
- Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Bariatric Surgery
- Chiropractic Care
- Routine foot care (for diabetics only)
- Telehealth/e-visit/video visit services

Your Right to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for these agencies is: South Dakota Department of Labor at 1-605-773-3101. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sanford Health Plan/Customer Service at 1-800-752-5863 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-857-4426 (toll free).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-857-4426 (toll free).
Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-855-857-4426 (toll free).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-857-4426 (toll free).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $2,500
- Specialist copayment $30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$2,500
Copayments	$0
Coinsurance	$1,250
What isn't covered	
Limits Or Exclusions	$60
The Total Peg Would Pay Is	$3,810

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $2,500
- Specialist copayment $30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits Or Exclusions	$60
The Total Joe Would Pay Is	$1,760

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible $2,500
- Specialist copayment $30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic tests (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	$1,930

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,400
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits Or Exclusions	$0
The Total Mia Would Pay Is	$1,600

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Sanford Wellness at 1-877-305-5463. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

SANFORD HEALTH PLAN

Non-discrimination notice

Sanford Health Plan: does not discriminate against any future, current, or past Member on the basis of race; ethnicity; color; national origin; disability; sex; gender; sexual orientation; gender identity; religion; spiritual beliefs; medical condition, including a current or past history of mental health and substance use disorders; sources of payment for care; or age, in its coverage, treatment, or benefit decisions. Sanford Health Plan:

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

If you need these services, contact Sanford Health Plan at 1-800-752-5863, 8 a.m. to 5 p.m. Central Time, Monday-Friday.

If you believe Sanford Health Plan has failed to provide these services or discriminated in any way. Contact our Director of Customer Service and Enrollment, 300 Cherapa Place #201, Sioux Falls, SD 57103, 1-605-328-6800, TTY Number 1-877-652-1844, memberservices@sanfordhealth.org. You can file a grievance in person, by mail, fax, or email.

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

Free help in other languages

For help in a language other than English, please call us toll-free at 1-855-857-4426. Both oral and written translation services are available for free in at least 150 languages. If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-857-4426 (TTY: 1-877-652-1844).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-857-4426 (TTY: 1-877-652-1844).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-857-4426 (TTY: 1-877-652-1844).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-857-4426 (TTY: 1-877-652-1844).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-857-4426 (TTY: 1-877-652-1844).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-857-4426 (TTY: 1-877-652-1844).

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Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-857-4426 (TTY: 1-877-652-1844).

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Karen:

Sanford Health Plan

1-855-857-4426

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-857-4426 (መስማት ለተሳናቸው: 1-877-652-1844).

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Cambodian, Mon-Khmer:
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-857-4426 (TTY: 1-877-652-1844)

Help understanding this document is free

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JobID: 582848 RP:4 13 / 2028 Section 4 of 28 Sheet: 13 Web Request

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Coverage Services
Lewis Drug, Inc. $4,000 | South Dakota
Coverage Period: 1/1/18 to 12/31/18
Coverage for: Individual + Family | Plan Type: HMO | Non-Grandfathered

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Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers $4,000 individual / $8,000 family. For out-of-network providers $6,000 individual / $12,000 family.	Generally, you must pay all the costs from the providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive care services are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at www.healthcare.gov/coverage/preventive-care-benefits
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	For network providers $6,000 individual / $12,000 family. For out-of-network providers $9,000 individual / $18,000 family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.sanfordhealthplan.org or call 1-800-752-5863 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / visit; Deductible does not apply	40% coinsurance	None
	Specialist visit	$30 copay / visit; Deductible does not apply	40% coinsurance	None
	Preventive care / screening / Immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. For details reference the Preventive Health Guidelines or contact Customer Service.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sanfordhealthplan.org	Generic drugs (Tier 1)	$15 copay / prescription; Deductible does not apply	Not Covered	Covers up to a 30 day supply. Some specialty medications may be obtained with a copay depending on where they are received or administered. Refer to your Summary of Pharmacy Benefits / Formulary to determine which benefit applies to your medication. Certain contraceptive drugs covered at 100%.
	Preferred brand drugs (Tier 2)	$35 copay / prescription; Deductible does not apply	Not Covered	
	Non-preferred brand drugs (Tier 3)	$50 copay / prescription; Deductible does not apply	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	These services require certification by the plan for in-network coverage levels to apply.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay / visit; Deductible does not apply	$150 copay / visit; Deductible does not apply	Copay waived if directly admitted. Out-of-network is the same as in-network benefit unless the plan determines the condition did not meet prudent layperson definition of emergency; then the out-of-network deductible and coinsurance applies. Member is responsible for charges above Reasonable Cost of defined by the Policy/Certificate of Insurance.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$30 copay / visit; Deductible does not apply	$30 copay / visit; Deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay / visit; Deductible does not apply and 20% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Inpatient services require certification by the Health Plan for in-network coverage levels to apply. For full details, please refer to your policy.
If you are pregnant	Office visits	$30 copay / visit; Deductible does not apply and 20% coinsurance for other outpatient services	40% coinsurance	Cost sharing does not apply for preventive services. Depending on the type of services copayment or coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. Limited to 40 visits per calendar year.
	Rehabilitation services	$30 copay / visit; Deductible does not apply and 20% coinsurance for ancillary services	40% coinsurance	Office Visit includes practitioner consults. Ancillary includes but is not limited to x-rays, labs, ultrasounds, and rehabilitation therapy. Limited to 30 visits per therapy per calendar year.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. Limited to 30 days in any consecutive 12-month period.
	Durable medical equipment	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. For full details, please refer to your Policy/Certificate of Insurance.
	Hospice services	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply.
If your child needs dental or eye care	Children's eye exam	No Charge	40% coinsurance	Covered when part of a preventive exam.
	Children's glasses	Not Covered	Not Covered	None
	Children's dental check-up	Not Covered	Not Covered	None

Excluded Services & Other Covered Services:

Services Your plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Cosmetic Surgery • Dental care (Adult) • Hearing Aids	• Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private Duty Nursing • Routine eye care (Adult) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery • Chiropractic Care	• Routine foot care (for diabetics only)	• Telehealth/e-visit/video visit services

Your Right to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for these agencies is: South Dakota Department of Labor at 1-605-773-3101. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sanford Health Plan/Customer Service at 1-800-752-5863 or contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes.
If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes.
If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

Language Access Services:
Spanish (Español): Para obtener asistencia en Español, llame al 1-855-857-4426 (toll free).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-857-4426 (toll free).
Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-855-857-4426 (toll free).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-857-4426 (toll free).

——— To see examples of how this plan might cover costs for a sample medical situation, see the next section. ———

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible $4,000
- Specialist copayment $30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Specialist office visits (prenatal care)
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (ultrasounds and blood work)
Specialist visit (anesthesia)

Total Example Cost	$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	$4,000
Copayments	$40
Coinsurance	$1,000
What isn't covered	
Limits Or Exclusions	$60
The Total Peg Would Pay Is	$5,100

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The plan's overall deductible $4,000
- Specialist copayment $30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Primary care physician office visits (including disease education)
Diagnostic tests (blood work)
Prescription drugs
Durable medical equipment (glucose meter)

Total Example Cost	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits Or Exclusions	$60
The Total Joe Would Pay Is	$1,760

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The plan's overall deductible $4,000
- Specialist copayment $30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic tests (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	$1,930

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,400
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits Or Exclusions	$0
The Total Mia Would Pay Is	$1,600

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Sanford Wellness at 1-877-305-5463. *Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

The plan would be responsible for the other costs of these EXAMPLE covered services.

SANFORD HEALTH PLAN

Non-discrimination notice

Sanford Health Plan: does not discriminate against any future, current, or past Member on the basis of race; ethnicity; color; national origin; disability; sex; gender; sexual orientation; gender identity; religion; spiritual beliefs; medical condition, including a current or past history of mental health and substance use disorders; sources of payment for care; or age, in its coverage, treatment, or benefit decisions. Sanford Health Plan:

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

If you need these services, contact Sanford Health Plan at 1-800-752-5863, 8 a.m. to 5 p.m. Central Time, Monday-Friday.

If you believe Sanford Health Plan has failed to provide these services or discriminated in any way. Contact our Director of Customer Service and Enrollment, 300 Cherapa Place #201, Sioux Falls, SD 57103, 1-605-328-6800, TTY Number 1-877-652-1844, memberservices@sanfordhealth.org. You can file a grievance in person, by mail, fax, or email.

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

Free help in other languages

For help in a language other than English, please call us toll-free at 1-855-857-4426. Both oral and written translation services are available for free in at least 150 languages. If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-855-857-4426 (TTY: 1-877-652-1844).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-857-4426 (TTY: 1-877-652-1844).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-855-857-4426 (TTY: 1-877-652-1844).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-857-4426 (TTY: 1-877-652-1844).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-855-857-4426 (TTY: 1-877-652-1844).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-855-857-4426 (TTY: 1-877-652-1844).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-857-4426 (TTY: 1-877-652-1844).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-857-4426 (телетайп: 1-877-652-1844)

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-857-4426 (TTY: 1-877-652-1844).

Arabic: ملحوظة: إذا كنت تتحدث فاذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-855-857-4426 (رقم هاتف الصم والبكم: 1-877-652-1844).

Karen:

[illegible] Sanford Health Plan [illegible] 1-855-857-4426 [illegible]

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-857-4426 (መስማት ለተሳናቸው: 1-877-652-1844).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-857-4426 (TTY: 1-877-652-1844).번으로 전화해 주십시오.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-855-857-4426 (ATS: 1-877-652-1844).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-857-4426 (TTY-Telefon za osobe sa oštećenim govorom ili sluhom: 1-877-652-1844).

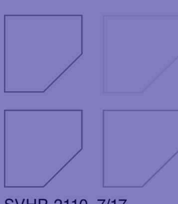
Cambodian, Mon-Khmer:
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-855-857-4426 (TTY: 1-877-652-1844)

Help understanding this document is free

If you would like this policy in another format (for example, a larger font size of a file for use with assistive technology, like a screen reader), please call us at: 1-800-752-5863 (toll-free) | TTY/TDD: 1-877-652-1844

Employee Assistance Program

SANFORD
HEALTH PLAN



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Toll Free Referral Line 888-450-7844
All calls and consultations are strictly confidential
24 hours, 7 days a week

Who We Are

KeySolutions EAP is a benefit provided by your employer to help you, and your immediate family members with many types of personal problems that may interfere with a productive life at home or work.

Why Your Employer is Offering EAP

Your employer knows that personal problems can reduce an employee's work performance. Fortunately, most of these problems can be solved with effective short-term counseling and can lead to improved performance.

What It Costs

Your employer has a contract with KeySolutions EAP. That covers the cost of a limited number of counseling sessions for you. If long term counseling is needed, it may be covered by insurance or other benefits. Services to your immediate family are free since your well-being is affected by the concerns you have for your spouse or dependents.

How Do You Know If You Need Help

- Feeling out of control with your life
- Feeling consistently unhappy, short-tempered or withdrawn
- Money problems causing stress and problems with relationship
- Frustration at work and you don't know how to deal with it
- Low energy level and frequent tiredness
- Self-isolation from friends and social activities
- Negative attitude and hopelessness
- Your child's behavior is out of control and your feel helpless trying to deal with it.

All counseling sessions *must be preauthorized.*

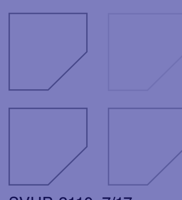
Please contact Keysolutions at 888-450-7844

www.keysolutionseap.com

A service of Keystone Treatment Center

Flexible Spending

SANFORD
HEALTH PLAN



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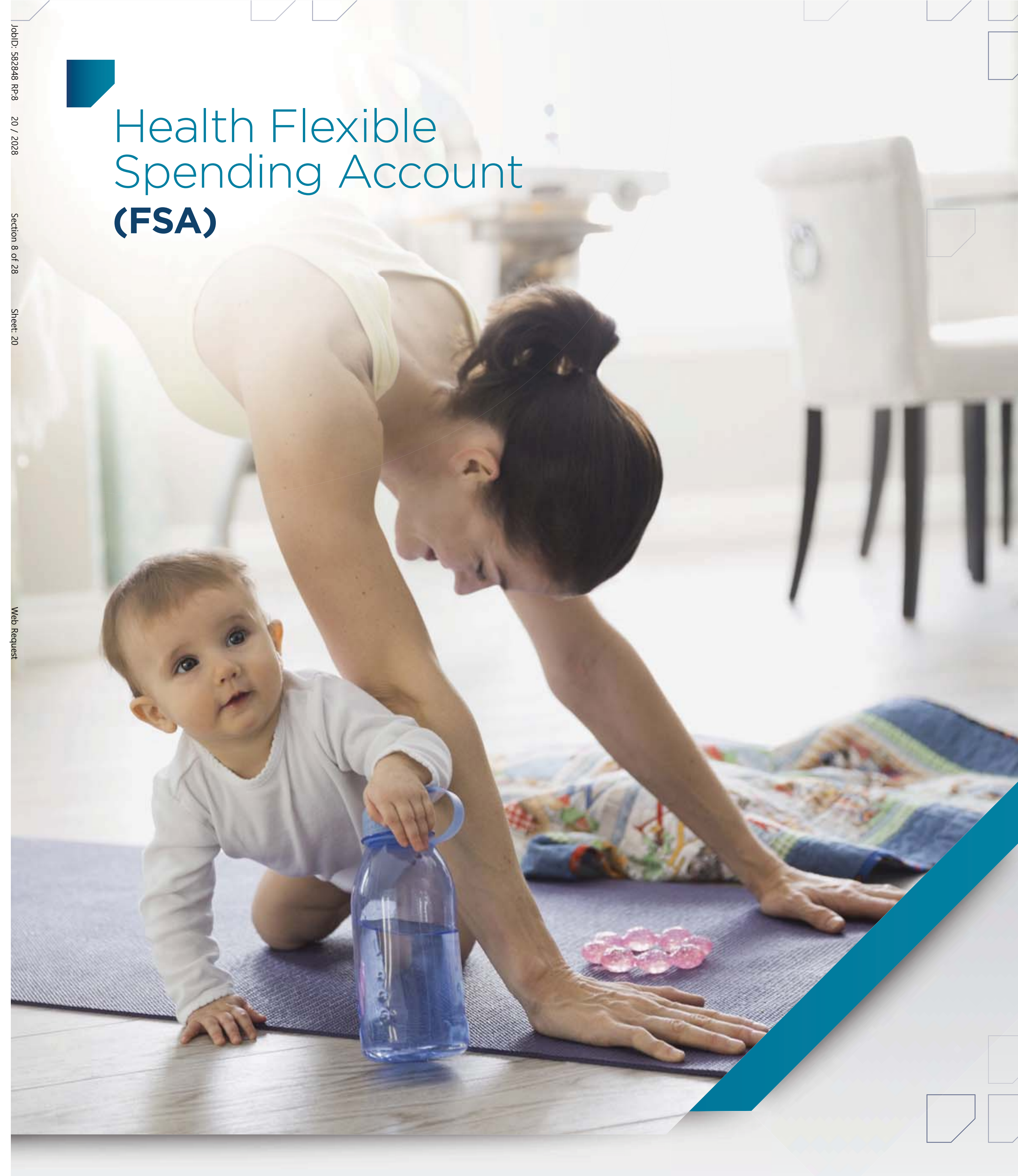
Health Flexible Spending Account (FSA)



SANFORD HEALTH PLAN

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QUICK TIP

Save money on taxes — enroll in a Health FSA today!

QUICK TIP

Check with your employer for the maximum you can elect. It may be lower than the IRS limit.

Health Flexible Spending Account (FSA)

Do you realize how much you spend each year on your out-of-pocket medical expenses? What if you could save money on those expenses? Enrolling in a Health FSA can save you money by saving you tax dollars.

What is a Health Flexible Spending Account?

A Health FSA is a special account designed to pay for certain out-of-pocket health care costs. If you have medical, dental or vision expenses, a Health FSA may be right for you.

You choose an amount to put into your FSA. This is called your election. This amount comes out of each paycheck before taxes, increasing your take home pay. The amount of savings will depend on your yearly health care expenses and your personal tax situation.

Use the account to pay for medical expenses for you, your spouse or your eligible dependents. Eligible expenses include those that your insurance does not pay, including:

- Medical and pharmacy copays
- Amounts that apply to your deductible or coinsurance
- Vision care services
- Dental or orthodontia care services
- Certain over-the-counter items

How to use your FSA

1. Decide

- Use the worksheet on page 6 to estimate your yearly expenses and decide how much to set aside. Remember to include expenses for your spouse and/or tax dependents, but be conservative. Most plans do not allow you to carry over funds to the next year and you don't want to lose them.
- Employers often set the limit on your election amount. It cannot be more than $2,600, as determined by the IRS, but the amount can be less if your employer chooses.

NOTE: You cannot change your elections during the plan year unless you have a specific life event which may include:

- Marriage or divorce.
- Birth or adoption of a child.
- Death of your spouse or child.
- Change in employment status for you or your spouse.
- An unpaid leave of absence by you or your spouse.

2. Contribute

- Once you decide on your election amount, that amount is deducted (before taxes) in equal amounts from each of your paychecks and kept in an account for your use during the plan year.

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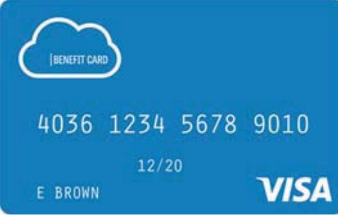
3. Use your dollars

- Use your Benny Card (see below) for qualified purchases at approved stores or providers.
- Pay with your own credit card, cash or check, then log on to your secure account or mobile app and file a claim. You will receive your reimbursement by direct deposit into your designated account.
- Keep your itemized receipts. You may need them to validate a debit card transaction.



Benny Card

When you sign up for a Health FSA, you will receive two debit cards, called Benny Cards. The cards will be loaded with your annual election amount. Use these cards anywhere VISA is accepted when paying for eligible medical expenses. Debit card transactions are only allowed for services and products incurred during your plan year.

Save your receipts

IRS guidelines for FSA debit cards may require you to send in your receipt to prove that your expense was eligible and incurred within the proper plan year. If verification is needed, a letter or email will be sent to you. It is important that you return the letter and documentation promptly.

It should include:

- Name of doctor or store.
- Description of service provided or item purchased.
- Date of service
- Amount you paid.
- Name of person who received service or purchased item.
- Prescription name (if applicable).
- Total amount paid by insurance (if applicable).

Verification is not needed if your debit card transaction:

1. Matches your medical or pharmacy copay amount.
2. Occurred at a store/pharmacy that has auto-verification technology, known as IIAS (see tip #4).

How do I file a claim or send in my receipts?

- Use your mobile app — type in the claim, take a picture of your receipt and upload
- Use your online member account at sanfordhealthplan.com/memberlogin — type in the claim, scan your receipt and upload
- Fax to (605) 328-7207
- Email at flex@sanfordhealth.org
- Mail to: Sanford Health Plan Flex Department, PO Box 91110, Sioux Falls, SD 57109-1110

QUICK TIP

Most debit card transactions are automatically verified — nothing needed from you!

QUICK TIP

Inventory Information Approval System (IIAS) is technology used by retailers. The cash register program automatically verifies that your purchase is eligible.

What if I don't have my receipts?

If you've misplaced a receipt needed for your debit card verification, don't worry. Most pharmacies and clinics can provide them to you again. Simply call and ask for an itemized receipt or Explanation of Benefits. If you cannot provide your receipts, you can send in replacement claims. On rare occurrences, you may have to pay back the claim if the verification cannot be submitted.

Sample EOB (Explanation of Benefits)

What should your documentation look like?

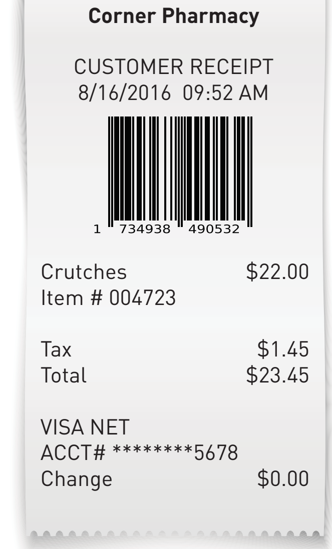
Member#: 11122233301 **Member Name:** Jane Doe **Provider:** 1234567892, Provider John
Claim#: 123456 **Vendor:** Sanford Clinic

Service Date	Description	Amount Billed	Discount Amount	Non-Covered Amount	Reason Codes	Allowed Amount	Copay	Deductible	Co-Insurance	Amount Paid
09/24/2013	73	117.00	70.49	0.00		46.51	0.00	46.51	0.00	0.00
09/24/2013	73	117.00	70.49	0.00		46.51	0.00	46.51	0.00	0.00
09/24/2013	98	226.00	70.31	0.00		155.69	20.00	0.00	0.00	135.69
Totals		460.00	211.29	0.00		248.71	20.00	93.02	0.00	135.69

The total member responsibility for this claim is: $113.02

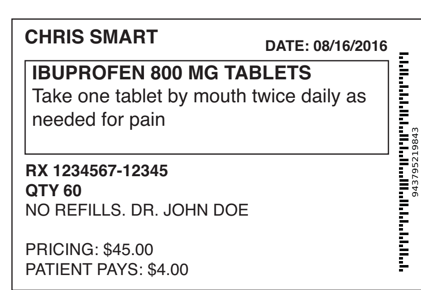
QUICK TIP

You can find claim forms online in your member account at sanfordhealthplan.com/memberlogin. Your reimbursement will be deposited into your bank account automatically.



Acceptable receipt
This receipt has all the information needed for a verification.

- Provider (pharmacy name)
- Date of purchase
- Item or service
- Amount paid



Acceptable prescription receipt
This receipt has all the information needed for a verification.

- Provider (pharmacy name)
- Patient name
- Date of purchase
- Prescription name
- Amount you paid

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Example of how a medical expense spending account works

The Smart family consists of Chris and Kara and their two children: Hannah and Frank. Chris and Kara have a combined annual income of $56,000.

Typical yearly expenses for the Smart family:

Deductibles, coinsurance and medical copayments	$900
Other eligible health services	$100
Pair of glasses	$220
Eligible dental expenses	$200
Prescription drug copayments	$380
TOTAL $1,800	

The Smarts elect $1,800 for their Health FSA. Here's a comparison:

	Without a Health FSA	With a Health FSA
Gross Income	$56,000	$56,000
Annual Election Amount	0	(1,800)
Taxable Income	56,000	54,200
Federal/State Taxes (25%)	(14,000)	(13,550)
After-tax healthcare expenses	(1,800)	0
Net take-home pay	$40,200	$40,650

Health FSA savings = $450 per year

These calculations are for illustration only.

The Smarts saved $450 by using a Health FSA.

Examples for orthodontic treatment

Orthodontic reimbursements require a proof of payment and a plan of treatment or financial contract. Payment dates must be within your eligible plan year in order to get reimbursed.

Here are two examples of orthodontic reimbursements for the Smart family. Hannah needs braces that will cost $4,575:

Treatment fee	$ 4,575
Less paid by insurance	($1,500)
Less down payment	($615)
Unpaid balance	**$2,460**

EXAMPLE #1

The Smarts make 24 monthly payments of $102.50 beginning June 2017.

Plan Year 2017 – claims filed for $1,332.50 ($615.00 down payment plus $102.50 x 7 months)
Plan Year 2018 – claims filed for $1,230.00 ($102.50 x 12 months)
Plan Year 2019 – claims filed for $512.50 ($102.50 x 5 months)

EXAMPLE #2

The Smarts pay the full amount in one payment of $3,075 on the date that the braces were placed, or May 23, 2017.

Plan Year 2016 – claim filed for $3,075

Health Flexible Spending Account worksheet instructions

To help decide your election amount for the Health FSA, fill in the amounts spent last year as a guide to estimate this year's expenses. Include only expenses you pay out-of-pocket — do not include amounts covered by your medical coverage. Per IRS guidelines, health insurance premiums are not eligible for Health FSA reimbursement.

TYPE OF EXPENSE	PREVIOUS YEAR	CURRENT YEAR ESTIMATE
Medical Care		
Copayments/Deductibles/ Coinsurance	$	$
Prescription Drugs	$	$
Other	$	$
Vision Care		
Vision Exams	$	$
Eyeglasses/Contact Lenses	$	$
Hearing Care		
Hearing Exams/Aids	$	$
Dental Care		
Copayments/Deductibles/ Coinsurance	$	$
Orthodontics (Braces)	$	$
TOTAL	**$**	**$**

mySanfordFlexPlan

Create a secure member account at sanfordhealthplan.com/memberlogin or download themySanfordFlexPlan app for your mobile device or tablet.

- Check your flex account balance
- Submit requested debit card receipts
- View the status of claims
- Send a secure message

Call (877) 737-7730 for more information.

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What expenses are eligible?

Eligible expenses include, but are not limited to:

- Acupuncture
- Alcoholism treatment
- Ambulance
- Artificial limbs/teeth (excluding veneers)
- Birth control pills/prescription contraceptives
- Screening tests for medical diagnosis
- Breast reconstruction surgery following mastectomy for cancer
- Chiropractor
- Contact lenses
- Crutches
- Dental services (not cosmetic)
- Prescription eyeglasses/eye surgery
- Laser eye surgery
- Hearing aids
- Prescription medicines (not cosmetic)
- Nursing home medical care
- Nursing services
- Optometrist
- Orthodontia (treatment plan needed)
- Over the counter medications (with doctor's prescription)
- Oxygen
- Psychiatric care for medical conditions
- Stop-smoking programs
- Surgery (other than cosmetic surgery)
- Therapy (medical care)
- Transplants
- Weight-loss program (prescribed by a physician for a specific medical condition)
- Wheelchairs
- X -ray fees

Non-eligible expenses include:

- Vitamins and dietary supplements
- Cosmetic services and products
- Cobra premiums
- Teeth whitening and toothpaste
- Non-prescription sunglasses
- Veneers

QUICK TIP

For a full list of expenses allowed by the IRS, see IRS publication 502.

irs.gov/pub/irs-pdf/p502.pdf

Dependent Care Spending Account (DCAP)

Save money on your dependent care and gain tax savings by enrolling in a dependent care spending account.

QUICK TIP

To be reimbursed for dependent care expenses, the IRS requires that you (and your spouse) must be working, looking for work or attending school full time.

What is a Dependent Care Spending Account (DCAP)?

A DCAP is a special account designed to pay for certain dependent care expenses. You choose an amount to put into your DCAP. This is called your election which comes out of each paycheck before taxes, increasing your take home pay and saving you money.

The amount of savings will depend on your yearly daycare expenses and your personal tax situation. Use the account to pay for qualified dependent care expenses for children under age 13.

Examples include:

- Daycare
- Before or after school care
- Certain summer day camps
- Elder care (exceptions apply)

Dependent Care Spending Account vs. tax credit?

In most cases the DCAP is better than the tax credit. However, it depends on your personal situation. If you spend more than $5,000 per year in child care expense, you can take advantage of both options

QUICK TIP

When filing claims, you will be reimbursed up to the balance of your account and services must have already been provided.

How a Dependent Care Spending Account works

1. Decide

- Use the worksheet on page 11 to estimate your yearly dependent care expenses to decide how much you want to set aside. Be conservative as unused funds will be forfeited.
- If you are married and filing a joint tax return, or are a single parent, you can elect up to $5,000 per plan year. If you are married and filing separate tax returns, you can elect up to $2,500 per plan year.

2. Contribute

Once you decide on your election amount, that amount is deducted (before taxes) in equal amounts from each of your paychecks.

NOTE: You cannot change your election during the plan year unless you have a specific life event. Examples of life events include:

- A marriage or divorce.
- Birth or adoption of a child.
- Death of your spouse or child.
- Loss of your spouse's employment.
- Change in employment status for you or your spouse.
- An unpaid leave of absence by you or your spouse.
- A cost change (not associated by a relative).

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3. Use your dollars

- Once the daycare service has been provided, submit your claim online from your member account or mobile app.
- Complete and submit a paper claim form.
- You can be reimbursed for amounts up to the dollars available in your account.
- Attach documentation including the daycare provider name and identification number, dates of care and your child's name. (If submitting via the mobile app, use your camera and take a picture of your receipt. Then upload the photo to your account.)
- You will receive your reimbursement by direct deposit.

QUICK TIP

Complete the claim form entirely or your reimbursement could be delayed.

QUICK TIP

Use your online member account or mobile app for faster claim submission. Use your phone's camera to upload your receipt or documentation.

What expenses are eligible?

- **Care outside the home (i.e. baby sitter or daycare provider):** Dependents must be under age 13. For disabled individuals over age 13, the individual must spend at least eight hours per day in your home.
- **Dependent care center:** Expenses incurred for services provided by a dependent care center (i.e. facility providing care for more than six individuals not residing at the facility).
- P**ayments to relatives:** Expenses can be reimbursed to a relative, however the relative cannot be a dependent under the age of 19 at the end of the year in which the expenses were incurred.
- **Summer day camp:** Expenses incurred for a day camp that is primarily custodial in nature rather than educational. However, expenses for overnight camps are not considered work-related and are not eligible.

Non-eligible expenses include:

- Diapers or other supplies
- Meals (if billed separately)
- Late payment fees

Example of how a Dependent Care Spending Account works

Jane Doe, as a single parent, has two children: Judy, 7, and Rudy, 3. Jane's annual income is $40,000. She pays the cost of daycare for Rudy ($100 per week) and after-school care for Judy ($20 per week); $60 per week during the 12 weeks of summer vacation). This brings her total childcare expenses to $6,720 for the year.

Jane elects to deposit $5,000 per year in her Dependent Care Spending account. Here's a comparison:

	Without a Health FSA	**With a Health FSA**
Gross Income	$40,000	$40,000
Annual Election Amount	0	(5,000)
Taxable Income	40,000	35,000
Federal/State Taxes (25%)	(10,000)	(8,750)
After-tax dependent care expenses	(6,720)	(1,720)
Net take-home pay	$23,280	$24,530

Dependent Care Spending advantage $1,250 per year
These calculations are for illustration only.

Jane Doe saved $1,250 by using a Dependent Care Spending Account

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Dependent Care Spending Account worksheet instructions

Fill in the amounts you spent last year and use those figures as a guide to estimate this year's expenses. Do not include food or activity expenses if charged separately, as they are not allowed.

Remember, only those expenses necessary to provide care for a dependent while you and your spouse (if married) are working are eligible for reimbursement. A dependent can be any one of the following: a child under age 13, a disabled child, or a disabled spouse.

Type of Expense	Previous Year	Current Year Estimate
Daycare Center	$	$
Nursery School	$	$
After School Care	$	$
Child Care Services	$	$
Adult Daycare	$	$
TOTAL	**$**	**$**

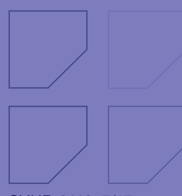
CONTACT US

Our team is ready to help if you have questions.

Toll-free at
(877) 737-7730
Monday – Friday
8 a.m. – 5 p.m. CT.

Online Resources

SANFORD®
HEALTH PLAN



SVHP-2110 7/17

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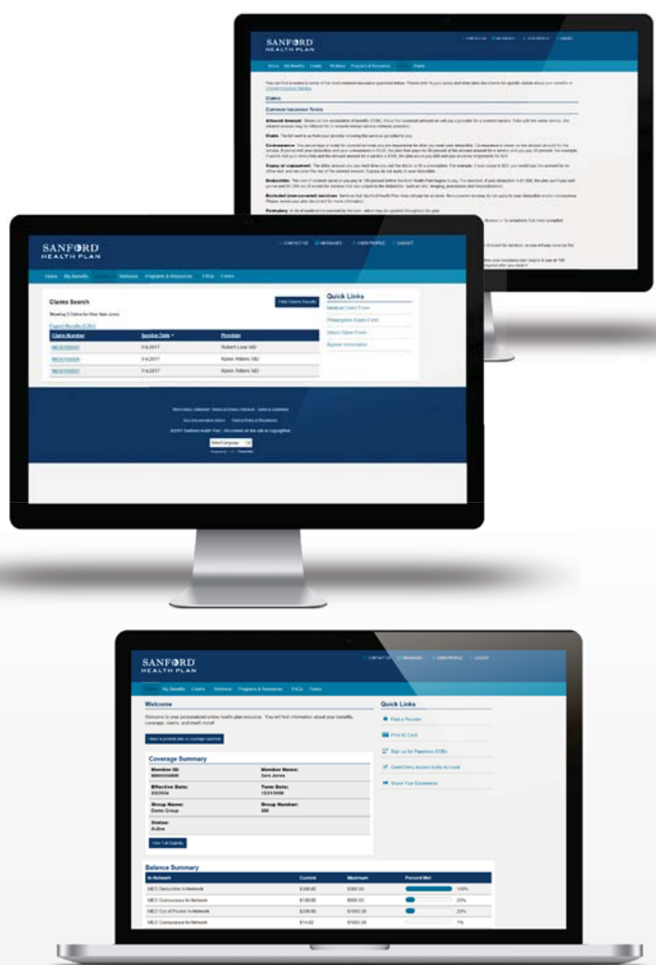
*my*SanfordHealthPlan

Simplify your life

Access your benefit information anytime, anywhere.

You have easy access to online and mobile tools, all designed to simplify your health care experience and interaction with Sanford Health Plan benefits and resources.

- **Quick Links**: Provider and pharmacy directories, online wellness portal, and member perks information are right at your fingertips.
- **Quick Answers:** View your out-of-pocket maximum, co-payments, deductibles, recent claims, flex balances and more.
- **Convenient results:** Easily reorder a misplaced card, ask a question and more.



Mobile app keyword search:
Sanford Health Plan

All you need is a few minutes and your Sanford Health Plan ID card to register.

Visit sanfordhealthplan.com/memberlogin.

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Your Online Wellness Portal

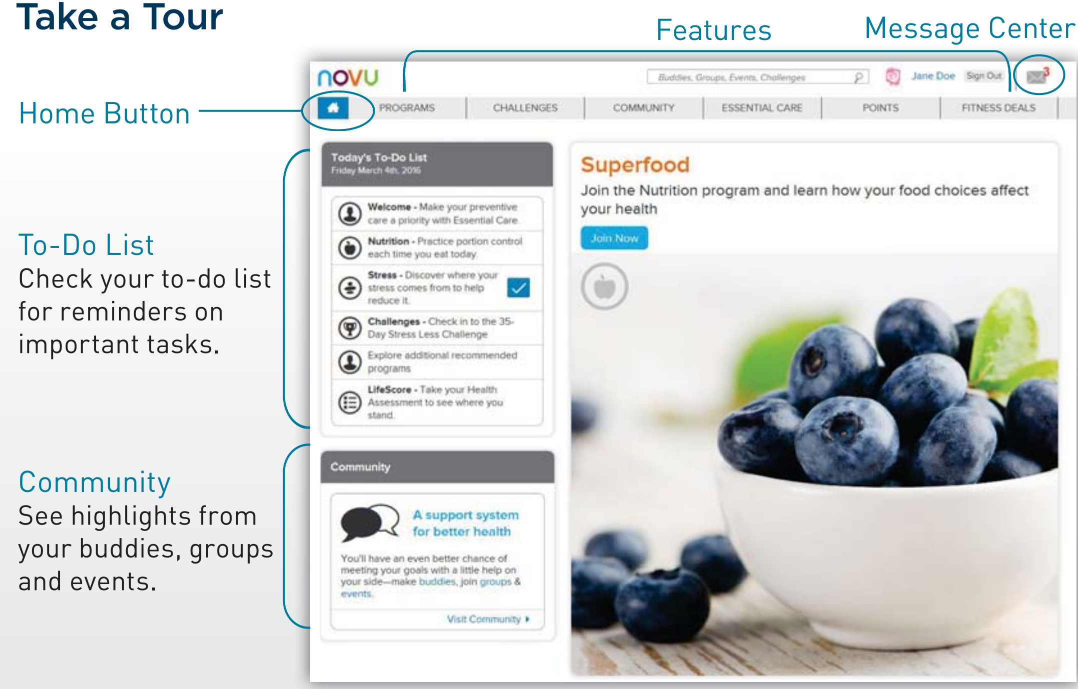
Connecting you and your health

As a Sanford Health Plan member, you have access to our online wellness portal. If you used the wellness portal in the past, you'll notice it has changed. If you are a new member or haven't used the wellness portal, give it a try. You can take a health assessment, try new health and well-being activities and get support on your wellness journey.

How to Access

Log on to your account at sanfordhealthplan.com/memberlogin. Select Wellness Portal under the My Information tab. If you do not have an account, use your medical ID card and click Create an Account.

Take a Tour



SANFORD HEALTH PLAN

Take Your Health Assessment

Health assessments are called LifeScores. You'll find this under the Essential Care tab. Find out what areas of your health and well-being are on track and what areas could use improvement. Based on your results, you will receive personalized recommendations to guide you toward better health. Your individual results are never shared with your employer.

Get Involved

Programs

Programs are educational step-by-step plans that guide you toward new and improved healthy habits.

Challenges

Challenges are opportunities to track specific daily activity while competing with others.

Community

Interact with others, engage in friendly competition or support co-workers. Get the most out of the community by getting involved!

Essential Care

Keep track of your scheduled preventive health and dental appointments.

Call (800) 752-5863 to contact our Member Services team with questions about your wellness portal.

SVHP-1713 Rev. 8/17

JobID: 582848 RP-12 29 / 2028 Section 12 of 28 Sheet 29
Web Request

E-VISITS

My Sanford Chart

Who can participate in an e-visit?

E-visits are available to both current and new patients in South Dakota and Minnesota.

What is an e-visit?

During an e-visit, you simply log on to My Sanford Chart, select the e-visit option and complete a brief questionnaire. One of our providers will review your information and provide you with a treatment plan, order a prescription if needed or request to see you in person.

You can expect a response in your My Sanford Chart account within four hours during normal hours of operation. The provider may choose to ask additional questions through My Sanford Chart as part of the e-visit.

What conditions can be addressed through an e-visit?

You may complete an e-visit questionnaire for a variety of health conditions including:

2 months - 2 years

- Diaper rash

2 months and older

- Head lice
- Insect bite
- Pink eye

12 years and older

- Acne
- Athletes foot

6 years and older

- Hayfever
- Rash
- Sunburn

18 years and older

- Back pain
- Breast feeding mastitis
- Cough
- Diarrhea
- Heartburn
- Influenza
- Sinus problems
- Urinary symptoms
- Vaginal discharge

Now available 24 hours a day, 7 days a week. Holiday hours may be available.

SVHP-1654 9/16

JobID: 582848 RP-13 30 / 2028 Section 13 of 28 Sheet: 30

VIDEO VISITS

Web Request

My Sanford Chart

Who can participate in a video visit?

Video visits are available to current patients in North Dakota and Iowa and both current and new patients in South Dakota and Minnesota.

What is a video visit?

Through a video visit you can see a health care provider from home, work or nearly anywhere in between. During a video visit, you can use your mobile device or computer to meet face to face with our medical team for any acute, non-emergent primary care need including coughs, colds, rashes, aches and pains. Video Visits are provided by Sanford Acute Care providers.

How do I request a video visit?

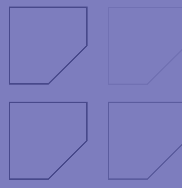
You may request a video visit with a Sanford Acute Care provider through your My Sanford Chart account.

- During the request for your video visit, you will answer several short questions about your health care concern.
- Based on the information you provide, your health care provider will schedule a time for your video visit or may recommend a clinic visit, if needed.
- Most appointments are scheduled within an hour of submitting a request through My Sanford Chart.

Now available 24 hours a day, 7 days a week.
Holiday hours may be available.

SVHP-1656 9/16

Wellness



SANFORD HEALTH PLAN

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Fitness Center Reimbursement

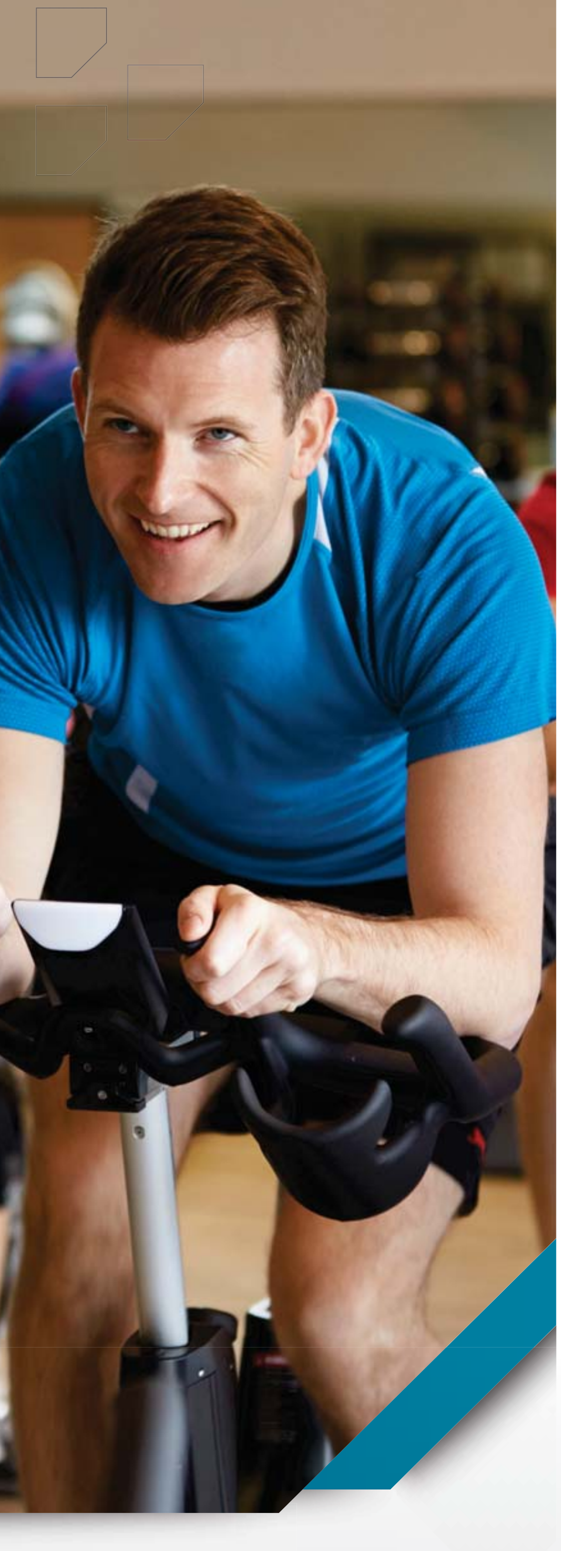
The Fitness Center Reimbursement Program provides up to a $20 monthly reimbursement when you use your fitness center a minimum of 12 days per month.

Member FAQ

Q. How do I get signed up for the fitness center reimbursement through Sanford Health Plan?

A. **Follow these steps:**

1. **Check with your employer to find out if the fitness center reimbursement is included in your employee health benefits.**
2. **Go to NIHCArewards.org to enroll online.**
   Under "Member Options", click "First Time Enrollment" and select Sanford Health Plan from the drop down menu. Search for your fitness center location by zip code. If your gym does not appear in the results, try increasing the search radius. Select your club and click "Enroll Online." Read and agree to the terms of service.
3. **Enter your contact, health plan and banking information and click "Submit."**
   Reminder for members with covered spouses: *Your workouts will be credited toward your insured number and your covered spouse's workouts will be credited toward their insured number, with a maximum monthly reimbursement of $40.*



Q. How and when will I be reimbursed?

A. Ask your fitness center about their reimbursement method. Most participants receive an automatic deposit into a bank account on or around the 21st of the following month.

Q. What if my club's monthly fees are less than $20 per month?

A. If your monthly membership is less than $20, your credit would reflect the amount you pay per month. For example, if your monthly membership fee is $9, you would then be credited $9 each month that you work out 12 days.

Q. I belong to a fitness center with multiple locations. Can I work out at any location and still have it count toward my 12 days per month requirement?

A. Only workouts that take place at the location where you first enroll will count toward your monthly credit. You must decide on a "home" fitness center.

Q. What if I don't receive my reimbursement?

A. You can see the status of your reimbursements in your member account at NIHCArewards.org. If there was an error that needs to be resubmitted, contact your fitness center.

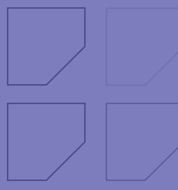
For assistance with other errors, contact Sanford Health Plan at (844) 742-0014. Errors must be resolved by February 8 of the following year. It is your responsibility to ensure your gym visits are recorded and payments are received.

Q. What if I terminate my fitness center membership?

A. If you voluntarily cancel your fitness center membership or if you become delinquent in your membership dues, you will not be eligible for reimbursements. If you move your gym membership to a new facility, log on to NIHCArewards.org and select your new gym to continue receiving reimbursements.

Enrollment

SANFORD
HEALTH PLAN



Application for Group Health Insurance

P.O. Box 91110
Sioux Falls, SD 57109
(605) 328-6800
(800) 752-5863
Fax: (605) 328-6811
sanfordhealthplan.com

This section must be completed by Human Resource Representative.
Incomplete forms will be returned and may cause processing delays.

Group Name:___________________________ Group/Division Number: _______________________________

Effective Date:___________________________ Date of Hire: ____

Reason for Enrollment: ☐New Hire ☐Open Enrollment ☐Late Entrant ☐Special Enrollment Reason: _____________

Signature of Company Representative____ Date: ______________

Please send originals to: PO Box 91110, SD 57109-1110

Employee Information

First Name, M.I., Last Name	Social Security #	Date of Birth (MM/DD/YY)

Mailing Address (Street Address)	City	State	Zip Code	County

Primary Phone Number	Work Phone Number	Family Physician

Gender: ☐ Male ☐ Female Marital Status: ☐ Married ☐ Single ☐ Divorced/Separated ☐ Other

What is your primary language? ☐ English ☐ Spanish ☐ Other ____

Coverage Election

☐ Single ☐Employee + Spouse ☐Employee + Child(ren) ☐Family

☐ NONE – I am declining coverage because I and/or my dependents have coverage through: ☐Spouse's Group Health Plan ☐Other
Explain:____

☐ Deductible Choice: (only for dual options) ____

Dependent Information – List all family members to be covered. Use additional sheet, if needed.

First Name, M.I., Last Name	Gender (M/F)	Date of Birth (MM/DD/YY)	Social Security #	Relationship[1]	Full Time Student[2] (Y/N)	Family Physician

Do all of the dependent(s) listed above reside at the same address as the employee? ☐ Yes ☐ No
If no, list dependent(s) name and address: ____

Provide additional information if answered 'Yes' above:

[1] For North Dakota and Minnesota applicants: If the unmarried parent of the grandchild is a covered eligible dependent and both the parent and grandchild are primarily dependent on the subscriber. Grandchildren must reside with subscriber.

[2] For South Dakota applicants: If the dependent is over age 26 and under age 30, and a full-time college student, please provide name of school/university, city and state:

____

[2] For Iowa applicants: If dependent is a full-time college student, please provide name of school/university, city and state:

____

Other Insurance Information

Are you currently, or have you been previously enrolled with Sanford Health Plan?
☐ Yes ☐ No If Yes, who? List ID# ______________________

Will you or any of your family members be covered by another health policy after the effective date of enrollment with Sanford Health Plan?
☐ Yes ☐ No If yes, you must complete the following information to coordinate benefits.

Person Insured	Employer of Insured	Insurance Company	Policy Number	Effective Date

List covered family members:

Is anyone named in the application eligible for Medicare? ☐ Yes ☐ No Name/Medicare Number: ___________________________

Health Assessment

Has anyone in this application for health insurance ever had, or ever been treated or diagnosed by a physician or medical professional for any conditions listed below? Provide details in the section provided below.

Yes	No		Yes	No	
☐	☐	AIDS or a positive HIV test	☐	☐	High Cholesterol
☐	☐	Allergy / Asthma	☐	☐	Infertility/Reproductive Organ Disorder
☐	☐	Back or Neck Disorder	☐	☐	Kidney/Bladder/Urinary Disorder
☐	☐	Blood Disorder	☐	☐	Liver Disorder
☐	☐	Bone/Joint/Muscular Disorder	☐	☐	Mental or Nervous Disorder
☐	☐	Cancer	☐	☐	Migraine Headaches
☐	☐	Diabetes/Pancreatic Disorder	☐	☐	Nervous System/Brain Disorder
☐	☐	Digestive/Intestinal Disorder	☐	☐	Respiratory/Lung Disorder
☐	☐	Drug or Alcohol Abuse	☐	☐	Skin Disorder
☐	☐	Eating Disorder	☐	☐	Stroke
☐	☐	Ear, Nose & Throat Disorder	☐	☐	Tumor or Cyst
☐	☐	Heart/Circulatory Disorder	☐	☐	Current Pregnancy; due date _____ /_____ /_____
☐	☐	High Blood Pressure			

Are you or any dependent listed on this application a tobacco user? ☐ Yes ☐ No If yes, list who:______________________

List any other condition, treated in the last 10 years, not mentioned above:____

☐ ☐ In the last year, has anyone received medical treatment apart from routine physicals or immunizations?

☐ ☐ Do you or any of your dependents take any medicines or require shots?

☐ ☐ Do you or any of your dependents have treatments, tests, hospitalization or surgery planned in the future?

Are any of these conditions related to a workers' compensation injury, motor vehicle accident or third party liability claim?

If yes, explain:____

If you checked yes to any health questions above, please complete this section. Use an additional page if needed and include your signature and date.

Name of Person	Name of Condition	Date of Onset and Duration of Treatment	Type of Treatment, Medication, and Degree of Recovery	Name and Address of Physician

Signature

On behalf of myself and my eligible dependents listed above, I hereby agree to the conditions of enrollment attached hereto. If applicable, my employer is authorized to deduct from my earning the necessary premium contributions, if any, required of me.

Signature of Employee	Date

HIPAA Authorization for Pre-Enrollment Uses and Disclosures of Member Information

I hereby authorize the use or disclosure of personal health information about me as described below.

I authorize Sanford Health Plan to use the personal health information I have provided on the application form to determine my eligibility to obtain coverage under the health benefits plan, for which I have applied, and to determine the rates and terms which apply to the plan/policy. I also authorize all health care providers and pharmacy benefit managers who have provided treatment or other health care services to me to disclose all information regarding my treatment to Sanford Health Plan. The following group of persons employed or working for Sanford Health Plan may use my personal health information disclosed herein: employees of the Underwriting, Customer Service, Flex and Medical Management departments. The information which is disclosed by health care providers may be used by Sanford Health Plan to determine my eligibility to obtain coverage under the health benefits plan, for which I have applied, and to determine the rates and terms which apply to the plan/policy. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by Sanford Health Plan in reliance on this authorization, by sending a written revocation to Sanford Health Plan, Attn: Customer Service, PO Box 91110, Sioux Falls, SD 57109-1110. I understand that the information which will be provided under this authorization is necessary for Sanford Health Plan to determine my eligibility for coverage under the health benefits plan and that Sanford Health Plan will condition enrollment in the health benefits plan/policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization. I understand that if the person or entity that receives my personal health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations. In the case of this authorization, however, the information described above will be received by a health plan which is covered by the federal privacy regulations, and will not be used or redisclosed except as described above, and the information will continue to be protected under the federal privacy regulations.

Applicant Name or Legal Representative[1] (print)	Applicant Signature	Date

1 If you are the legal representative of the applicant and are not the parent of a minor, you must attach evidence of your authority to act as the applicant's representative for this authorization to be valid (i.e. Power of Attorney).

Conditions of Enrollment

I agree for myself and on behalf of my eligible dependents to the following conditions of enrollment in Sanford Health Plan (hereafter referred to as the Plan).

1. We will abide by the rules and regulations of the Plan.
2. We will be bound by the eligibility requirements as stated in the Member Handbook, benefits, deductibles, copayments, coinsurance, exclusions, limitations, and other terms of the health maintenance contract and certificate of coverage.
3. We will complete and submit to the Plan such concepts, releases and other assignments as are reasonably necessary for the Plan in accordance with its rights under the health maintenance contract and certificate of coverage, to coordinate with other group health benefit plans or group insurance policies. I shall cooperate with and assist the Plan with respect to such coordination of benefits.
4. We will pay any copayments, deductibles or coinsurance as is required by the health maintenance contract or certificate of coverage directly to those providers who provide the health care services.
5. We acknowledge that we will be personally liable to the Plan for the usual and customary cost of any Health Care Services received during a time we are not eligible for coverage under the Certificate of Coverage.

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependent's other coverage).

However, you must request enrollment within 30 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption.

To request special enrollment or obtain more information, contact our Customer Service Department at (605) 328-6800 or toll-free at (800) 752-5863

Genetic Information Nondiscrimination Act of 2008 (GINA)

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Tile II from requesting or requiring genetic information of an individual or family member of the individual , except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member of an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Michelle's Law

Federal law requires that we provide the following notice regarding Michelle's Law [Public Law 110-381]. Please note that changes in federal law may eliminate certain elements of Michelle's Law, and the Plan intends to provide continuing coverage of Eligible Dependents up to age twenty-six (26), irrespective of their student status, for Plan Years beginning on or after September 23, 2010.

A Dependent Child enrolled in, and attending an accredited college, university, trade, or secondary school at least (5) months each year will remain covered if the Dependent takes a medically necessary leave of absence from school or changes to part-time status. The leave of absence must:

1. Be medically necessary;
2. Commence while the child is suffering from a serious illness or injury; and
3. Cause the child to lose coverage under the plan.

Students are only eligible as long as they were covered by their parent's health insurance policy prior to diagnosis. Coverage will continue until the earlier of one year from the first day of the leave of absence or the date on which coverage would otherwise terminate because the child no longer meets the requirements to be an Eligible Dependent (e.g., reaching the plan's limiting age).

You must provide a signed, written documentation from the Dependent Child's treating Practitioner/Provider stating all of the following: 1) the Dependent Child is suffering from a serious illness or injury necessitating a medical leave of absence; 2) the treating Practitioner/Provider certifies such leave of absence is Medically Necessary; and 3) the dates when the Dependent will be either on a medically necessary leave of absence from school or will be changing to part-time status due to a serious illness or injury.

Health Plan Use Only

Enrollment Application Audit Checklist

Please check off each category after audit is complete. Circle if information is incorrect and return to enrollment processor for corrections.

□ Social Security #	□ Sex (Male/Female)	□ Group #
□ Dependent student on review	□ Effective Date	□ Address
□ Date of hire	□ Date of Birth	□ Name spelling
□ Other insurance information	□ Pre-Ex Determination	□ Other:________________

Auditor: ________________________ Date:____________________ Processor:_____________________ Date:_________________

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Enrollment Application
Flexible Spending Arrangement

Employee Information (*required information)

*Name: (Last, First, M.I.) ______

*Street: ______ *Phone: (____) ______

*City: ______ *State: ______ *Zip: ______

*SSN: ______ *Date of Birth: ______ *Date of Hire: ______

*Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed *Gender: ☐ Male ☐ Female

*Employer: ______ Employee ID: ______ Email: ______

Dependent Information

Sanford Health Plan does not require dependents to be *enrolled* in the flex plan. However, dependents will remain eligible for submission of claims (see note below). Dependent names and ages will continue to be required on claim forms.

Note: Medical Expense Account: Eligible dependents include a participant's spouse and/or dependent child (who is younger than 27 at the end of the calendar year). Dependent Care Account: Eligible dependents include a participant's child who is younger than 13.

Employee Status

☐ New enrollee effective: ______

☐ Termination effective: ______

☐ Employee on Leave of Absence
From: ______ To: ______

☐ Change in Status effective: ______
Reason for status change:
☐ Change in marital status
☐ Change in dependents (birth/adoption/other)
☐ Change in employment status
☐ Other: ______

Note: Elections cannot be changed during the plan year unless there is a "status" change including, but not limited to: change in legal marital status, change in number of dependents, change in employment status, dependent satisfies (or ceases to satisfy) dependent eligibility requirements, and commencement or termination of adoption proceedings. Consistency rules apply.

* Pre-Tax Premium Agreement (Check one)

☑ I agree to have my gross salary redirected to pay my required contributions/premiums for benefits sponsored by my Employer's Flexible Benefit Plan, in accordance with Section 125 of the Internal Revenue Code. I instruct my employer to make these contributions on my behalf. If my required contributions for the elected benefits are increased or decreased while this agreement remains in effect, I understand that my salary redirection will automatically be adjusted to reflect that increase or decrease.

* Election Amounts

I, the undersigned, do hereby elect to participate in my employer's FLEX Program. I elect to reduce my cash compensation by the amounts set below, and receive, instead, the following benefits.

Compensation Reduction Amounts

	$ per paycheck		# of paychecks per year		Total Annual Election
Spending Accounts					
Dependent Care	$ ______	X	______	=	$ ______
Note: Eligible dependents are dependents of the tax payer as defined in Section 152(a) who have not attained age 13.					
Unreimbursed Medical Care	$ ______	X	______	=	$ ______
Total	**$** ______				**$** ______

* Bank Account Information

Your flex reimbursement will be paid to you by direct deposit. Attach a voided check if this is your initial flex election or if you need to make a change on your existing bank account.

Please attach voided check here

IRS Code Regulations/Employee Authorization

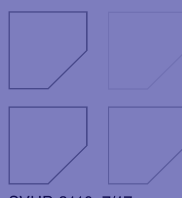
- Any unused balances in your Medical Care or Dependent Care Expense Account at the end of the plan year are forfeited. *Exception:* If your plan has been amended for IRS Notice 2005-42, you may have a grace period (after end of plan year) to incur expenses to use any remaining funds from your flex account at the end of the plan year.
- Expenses paid through your spending accounts are not eligible as personal deductions on your income taxes. Eligible medical expenses must be incurred by you or your eligible dependent (IRC Section 151/152) as described in IRC Section 213 (eligible medical expenses do not include long-term care premiums) and be incurred within your period of coverage and not paid by any insurance or form of compensation. Eligible dependents include a participant's spouse and/or dependent child (who are younger than age 27 at the end of the calendar year). A detailed list of eligible medical expenses can be found in IRS Publication 502.
- If enrolled in the Dependent Care Expense Account, your Dependent Care Tax Credit will be reduced. Eligible dependents are dependents of the tax payer as defined in Section 152(a) who have not attained age 13. A detailed list of eligible dependent care expenses can be found in IRS Publication 503.
- You agree to indemnify and reimburse your employer on demand for any liabilities that may occur from any reimbursement made for a non-qualifying expense.
- Since flex elections reduce your wage base for social security and worker's compensation contributions, your death, disability, retirement, and survivor benefits from those programs will probably be reduced. Therefore, you agree that your employer, the plan coordinator, and the plan administrator will not be held liable for any social security or worker's compensation benefit reductions which may result from your participation in your flex account.

I, the undersigned, have read and agree to comply with the Internal Revenue Code Regulations. I understand that the amount elected will stay in effect throughout the Plan Year unless I have an eligible qualified life event and request a change. Furthermore, I understand if my required premium conversion account contributions should increase or decrease while this agreement is in effect, my compensation redirection will automatically be adjusted. I authorize Sanford Health Plan to initiate deposit to the bank account indicated above. I authorize credit entries and, if necessary, debit entries and adjustment for any credit entries made in error to my account. This authority is to remain in full force until I terminate this authorization in writing.

Employee Signature: ____ Date: ____________________

Provider Network

SANFORD HEALTH PLAN



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The facts about the Sanford Health Plan Network

With your Sanford Health Plan insurance, you have access to over 18,000 providers in South Dakota, Minnesota, Iowa, North Dakota and Nebraska. You should select providers from this network. If you do not live in one of the states mentioned above, you are allowed to use our national network, PHCS Healthy Directions or MultiPlan. These networks are only for members who reside, travel, or attend school outside our service area.

If your provider is not in the network, ask us to contact them by completing a Provider Nomination Form, found on our website or within our Provider Directory. If you don't have access to a computer, or have a question about doctors you can see, call our Member Services Team. They can help you from 8 a.m. to 5 p.m., Monday through Friday at (800) 752-5863. For TTY/TDD, call (877) 652-1844. This service is free.

Important: If you choose to go to an out of network, when access to an in-network provider is available, your claims may be denied or paid at a reduced level.

Finding participating providers

To find the additional providers now available to you, log in to the provider directory using your member ID. You can access the provider directory by using your secure online member account at sanfordhealthplan.com/memberlogin. (See *How to log in to the provider directory* at the right). The online provider directory will map each provider's location and show their phone number and if they are taking new patients.

Your primary care practitioner

A primary care practitioner (PCP) practices:

- Internal Medicine
- Family Medicine (General Practice)
- Pediatrics
- Obstetrics and Gynecology

You have the right to choose your PCP. If you are not satisfied with your PCP, you can choose another. We encourage you to use your PCP whenever possible. This ensures you have consistent care from a doctor who knows you best. If you have family coverage, each insured family member may select their own PCP.

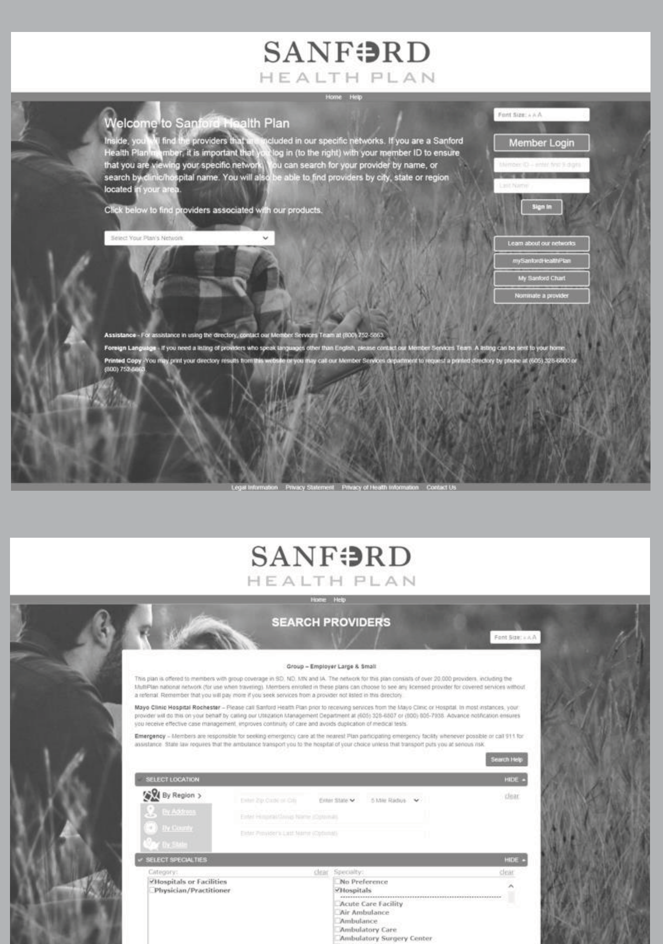
Your PCP can help you manage all your health care needs by evaluating your health, recommending and scheduling your services, and exchanging your information between all your doctors. Your PCP can contact our chief medical officer for questions regarding specialty care or services you may need (See *Specialty and Behavioral Health Services* page 2). If you need to see a specialist, make sure that all your medical records are sent to your PCP. It is important that your PCP has all your medical records to ensure seamless medical care between your PCP and specialty care providers.

When visiting any doctor, always show your Sanford Health Plan identification card.

How to log in to the provider directory

You can access the provider directory through *my*SanfordHealthPlan:

- Go to sanfordhealthplan.com/memberlogin
- Log in to your secure member account using your username and password
- Click on the "My Information" tab
- On the drop down menu, click "Find a provider"
- Access the member login section on the right side of the page
- Enter your member ID and last name



Transition of Care from a non-participating provider to a participating provider

If your group has just joined Sanford Health Plan, and you are currently receiving treatment from a doctor or facility that is not part of our network, you must receive approval to continue seeing your doctor. To request approval, complete a Transition of Care form within 30 days of your employer group's effective date. For this form, visit sanfordhealthplan.com/memberlogin, or call our Member Services Team at (800) 752-5863.

Please know that Transition of Care forms are only for specific types of treatment. Treatments that qualify include:

- You are pregnant and in your 2nd or 3rd trimester
- You have already planned a surgery
- You are receiving cancer treatment
- You are receiving transplant services
- You are receiving services where it would be deemed harmful to transition at this point of treatment
- You are undergoing active treatment for a disabling, chronic or acute medical condition
- You have a life threatening mental or physical illness
- You have a physical or mental disability defined as an inability to engage in one or more major life activities, the disability has lasted or can be expected to last for at least one year, or can be expected to result in death
- A physician certifies that there is an expected lifetime of 180 days or less (pursuant to Minnesota Statute 62Q.56)

Sanford Health Plan will review the Transition of Care form and send you a letter with one of the following decisions.

- The services may be authorized if found medically necessary; or
- A limited number of visits may be approved until you change to a provider that is in our network; or
- The services may be denied because there is adequate access to providers within our network.

Specialty and behavioral health services

We work with a large network of specialty providers to give you access to the health care services you need. If necessary, your PCP will refer you to a specialist or behavioral health specialist within our network. You can also see a participating specialist or behavioral health specialist on your own. If you have trouble getting an appointment with a behavioral health provider, call the behavioral health assessment line (800) 691-4336. It is available to you 24 hours a day.

Referrals to providers who are not in our network

Appointments with out of network providers must be pre-approved by Sanford Health Plan. If approved and your services are eligible, your claims will be processed at the in-network benefit level. For more details, please see the *Utilization Review* or the *Levels of Coverage* sections in the Member Handbook or your Policy, Summary Plan Description.

Mayo Clinic Health System, Rochester, Rochester Methodist and St. Mary's

If you need to receive services from the Mayo Clinic Health System, Rochester, or St. Mary's, you must call Sanford Health Plan and receive prior approval/authorization. Call our Utilization Management Team at (800) 805-7938.

Practitioner qualifications

If you would like more information about your provider's qualifications, please call us toll free at (877) 305-5463.

Foreign language services

Our provider directory includes providers who speak languages other than English. If you don't have access to a computer, you can call Member Services to request a listing of these providers. If you do not speak English and would like an interpreter, call LanguageLine Solutions at (800) 892-0675. This is a free service.

After hours care

Your PCP is available to you personally or through another provider 24 hours a day, seven days a week. Be sure to call during normal office hours for routine situations. After hours calls are only for urgent or emergency situations. Leave a message on your PCP's answering service, and they will call you back within 30 minutes or as soon as possible.

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Emergency

If you require immediate surgical or medical attention, call 911 or go to the nearest emergency room. We cover any emergency services necessary to screen and stabilize members when a prudent layperson, acting reasonably, would believe that an emergency medical condition exists. Sanford Health Plan covers any emergency at any emergency room, in or out of the plan's network, without the need for certification/prior-authorization from Sanford Health Plan. You will be required to pay only the in-network copay, coinsurance and/or deductible listed in your Summary of Benefits & Coverage.

Network options outside of the Sanford Health Plan service area

PHCS Healthy Directions and MultiPlan Networks*

Sanford Health Plan partners with a national network called PHCS Healthy Directions or Multiplan. This network is available only to those members who reside, travel or attend school outside our service area. You can find providers in these networks by accessing your secure member account (sanfordhealthplan.com/memberlogin) or at sanfordhealthplan.com. If these national networks do not provide you with access to a needed provider, then "Access and Availability" rules will apply. Please refer to your Policy, Summary Plan Description for details.

Important: If you choose to go to a provider that is not in our network, when access to an in-network provider is available, your claims may be denied or paid at a reduced level.

PreferredOne Network

If you are a Minnesota resident and have the PreferredOne logo on your ID card *and* do not have access to a Sanford Health Plan participating provider, you may access the Preferred One Network. You can find providers in these networks by accessing your secure member account (sanfordhealthplan.com/memberlogin) or at sanfordhealthplan.com. If this network does not provide you with access to a needed provider, then "Access and Availability" rules will apply. Please refer to your Policy, Summary Plan Description for details.

Important: If you choose to go to a provider that is not in our network, when access to an in-network provider is available, your claims may be denied or paid at a reduced level.

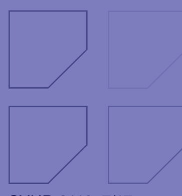
Pharmacy Networks

Express Scripts Inc.

Sanford Health Plan has partnered with Express Scripts Inc. to deliver your medical and outpatient prescription drug services. You must fill your prescription at any pharmacy that is included in this network. If you use a pharmacy not in this network, except in an emergency, you are responsible for the prescription drug cost in full. You must also show your Sanford Health Plan ID card to fill a prescription. If you don't have access to a computer, or if you have questions about pharmacies in this network, contact our Member Services Team at the toll-free number (800) 752-5863. For TTY/TDD call (877) 652-1844. This is a free service. A listing of participating pharmacies can be found online within your secure member account at sanfordhealthplan.com/memberlogin.

Special Notices

SANFORD® HEALTH PLAN



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Special Notices

for Group Plans

Special Enrollment Notice

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance, including group health plan coverage, Medicaid or State Children's Health Insurance Program (SCHIP), you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward you or your dependents other coverage). However, you must request enrollment within the following time periods:

- 31 days after you or your dependents' other group health plan coverage ends (or after the employer stops contributing toward the other coverage).
- 60 days after the date of termination of Medicaid or SCHIP coverage.

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, or you become eligible for state premium assistance under a Medicaid or a SCHIP, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption and 60 days after the date of eligibility for state premium assistance is determined.

To request special enrollment or obtain more information, contact our Customer Service Department toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844.

Premium Assistance under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial (877) KIDS NOW or insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at askebsa.dol.gov or call (866) 444-EBSA (3272).

ALABAMA – Medicaid	FLORIDA – Medicaid
Website: myalhipp.com Phone: (855) 692-5447	Website: flmedicaidtplrecovery.com/hipp Phone: (877) 357-3268
ALASKA – Medicaid	**GEORGIA – Medicaid**
The AK Health Insurance Premium Payment Program Website: myakhipp.com Phone: (866) 251-4861 Email: CustomerService@MyAKHIPP.com *Medicaid Eligibility* Website: dhss.alaska.gov/dpa/Pages/medicaid/default.aspx	Website: dch.georgia.gov/medicaid - *Click on Health Insurance Premium Payment* (HIPP) Phone: (404) 656-4507
ARKANSAS – Medicaid	**INDIANA – Medicaid**
Website: myarhipp.com Phone: (855) MyARHIPP ((855) 692-7447)	*Healthy Indiana Plan for low-income adults 19-64* Website: in.gov/fssa/hip Phone: (877) 438-4479 *All other Medicaid* Website: indianamedicaid.com Phone (800) 403-0864
COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)	**IOWA – Medicaid**
Health First Colorado Website: healthfirstcolorado.com Member Contact Center: (800) 221-3943/ State Relay 711 *CHP+* Website: colorado.gov/pacific/HCPF/Child-Health-Plan-Plus Customer Service: (800) 359-1991/ State Relay 711	Website: dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp Phone: (888) 346-9562
KANSAS – Medicaid	**NEW HAMPSHIRE – Medicaid**
Website: kdheks.gov/hcf Phone: (785) 296-3512	Website: dhhs.nh.gov/oii/documents/hippapp.pdf Phone: (603) 271-5218
KENTUCKY – Medicaid	**NEW JERSEY – Medicaid and CHIP**
Website: chfs.ky.gov/dms/default.htm Phone: (800) 635-2570	*Medicaid* Website: state.nj.us/humanservices/dmahs/clients/medicaid/ Phone: (609) 631-2392 *CHIP* Website: njfamilycare.org/index.html Phone: (800) 701-0710

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LOUISIANA – Medicaid	NEW YORK – Medicaid
Website: dhh.louisiana.gov/index.cfm /subhome/1/n/331 Phone: (888) 695-2447	Website: health.ny.gov/health_care/medicaid Phone: (800) 541-2831
MAINE – Medicaid	**NORTH CAROLINA – Medicaid**
Website: maine.gov/dhhs/ofi/public-assistance/index.html Phone: (800) 442-6003 TTY: Maine relay 711	Website: dma.ncdhhs.gov/ Phone: (919) 855-4100
MASSACHUSETTS – Medicaid and CHIP	**NORTH DAKOTA – Medicaid**
Website: mass.gov/eohhs/gov/departments/masshealth Phone: (800) 462-1120	Website: nd.gov/dhs/services/medicalserv/medicaid Phone: (844) 854-4825
MINNESOTA – Medicaid	**OKLAHOMA – Medicaid and CHIP**
Website: mn.gov/dhs/people-we-serve/seniors/health-care/health-care-programs/programs-and-services/medical-assistance.jsp Phone: (800) 657-3739	Website: insureoklahoma.org Phone: (888) 365-3742
MISSOURI – Medicaid	**OREGON – Medicaid**
Website: dss.mo.gov/mhd/participants/pages/hipp.htm Phone: (573) 751-2005	Website: healthcare.oregon.gov/Pages/index.aspx oregonhealthcare.gov/index-es.html Phone: (800) 699-9075
MONTANA – Medicaid	**PENNSYLVANIA – Medicaid**
Website: dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: (800) 694-3084	Website: dhs.pa.gov/provider/medicalassistance/healthinsurancepremiumpaymenthippprogram/index.htm Phone: (800) 692-7462
NEBRASKA – Medicaid	**RHODE ISLAND – Medicaid**
Website: dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: (855) 632-7633	Website: eohhs.ri.gov/ Phone: (401) 462-5300
NEVADA – Medicaid	**SOUTH CAROLINA – Medicaid**
Website: dwss.nv.gov/ Phone: (800) 992-0900	Website: scdhhs.gov Phone: (888) 549-0820
SOUTH DAKOTA - Medicaid	**WASHINGTON – Medicaid**
Website: dss.sd.gov Phone: (888) 828-0059	Website:hca.wa.gov/free-or-low-cost-health-care/programadministration/premium-payment-program Phone: (800) 562-3022 ext. 15473

TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: gethipptexas.com/ Phone: (800) 440-0493	Website: dhhr.wv.gov/bms/Medicaid%20 Expansion/Pages/default.aspx Phone: (877) 598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	**WISCONSIN – Medicaid and CHIP**
Medicaid Website: medicaid.utah.gov/ *CHIP* Website: health.utah.gov/chip Phone: (877) 543-7669	Website: dhs.wisconsin.gov/publications/p1/ p10095.pdf Phone: (800) 362-3002
VERMONT– Medicaid	**WYOMING – Medicaid**
Website: greenmountaincare.org Phone: (800) 250-8427	Website: wyequalitycare.acs-inc.com Phone: (307) 777-7531
VIRGINIA – Medicaid and CHIP	
Medicaid Website: coverva.org/programs_premium_ assistance.cfm Phone: (800) 432-5924 *CHIP* Website: coverva.org/programs_premium_ assistance.cfm Phone: (855-) 42-8282	

Privacy

Confidentiality and Disclosure of Personal Health Information

Sanford Health Plan receives and maintains a great deal of personal health information about our Members and we protect the privacy of all patient information in accordance with state privacy and federal HIPAA regulations.

We will share personal health information of Members as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our Members' personal health information and to provide Members with notice of our legal duties and privacy practices with respect to your personal health information.

No use or disclosure of personal health information may be made by any applicable person to a plan sponsor (i.e. employer) unless at least one of the following conditions is met:

1. Sanford Health Plan receives a signed certification from the employer that the plan documents restrict the use and disclosure of personal health information as required by the HIPAA regulations on privacy and confidentiality, and that the employer agrees to comply with the restrictions, and the information has been requested by the employer for use in carrying out plan administrative functions only (i.e. employers must certify they do not use or disclose the information for employment-related actions and decisions);
2. The information provided to the employer is summary health information, and the employer has requested it for the purpose of obtaining premium quotes, or determining whether to amend, modify or terminate the sponsored health plan (summary health information means personal health information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom an employer has provided health benefits under a group health plan, and from

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which all individual identifiers are eliminated);

3. The information provided to the employer is enrollment or disenrollment information or information on whether individuals are participating in the sponsored plan, and the employer has requested it for the purpose of administering the sponsored plan; or
4. There is a signed authorization by the Member or the Member's representative, which specifically authorizes the use or disclosure. A signed authorization form is required for uses by or disclosures to an employer if the use or disclosure does not meet the conditions described in paragraph 1, 2 or 3 above. Prior to any use by or disclosure to an employer under this paragraph 4, the procedures for obtaining and verifying authorization described in the policy for Obtaining and Complying With Member Authorizations must be followed.

Protection of Oral, Written and Electronic Information Across the Organization

All Members of our workforce are required to comply with the provisions of the Plan's workforce policy on General Obligations Regarding Uses and Disclosures of Personal Health Information. We consider workforce to include employees (Part time, Full time, and PRN), volunteers, trainees, and other persons whose work performance is under the direct control of Sanford Health Plan, whether or not they are paid by Sanford Health Plan.

- Personal health information of a Member may not be used within Sanford Health Plan for non-health plan functions, unless such use or disclosure is specifically authorized by a signed authorization by the Member.
- When using, requesting or disclosing a Member's personal health information, all reasonable efforts are made to limit the information used, requested or disclosed to that which is minimally necessary to accomplish the purpose of the use or disclosure in accordance with our Minimum Necessary Policy.
- All workforce members must attend required educational and training sessions relating to privacy and confidentiality of personal health information.
- All workforce members must take reasonable steps to safeguard personal health information from any intentional or unintentional use or disclosure that is in violation of this or any other policy of Sanford Health Plan. Such safeguarding includes, but is not limited to, storing personal health information in a cabinet or closed file at the end of the workday; maintaining privacy during oral discussions of personal health information; restricting electronic transmission of personal health information to job related duties; and disposing of documents strictly in accordance with policies of Sanford Health Plan.
- Sanford Health Plan will take appropriate disciplinary measures against workforce members who violate any policy or procedure of Sanford Health Plan concerning the privacy of member information. Discipline for such infractions of our privacy policies and procedures may include reprimand, suspension, or discharge of the responsible workforce member, depending on the severity of the misconduct.

Notice of Privacy Practices

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

This Notice applies to Sanford Health Plan. If you have questions about this Notice, please contact our Customer Service Department at (800) 752-5863 (toll-free) | TTY/TDD (877) 652-1844 (toll-free). You may also email your questions to memberservices@sanfordhealth.org.

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

How We Use and Disclose Your Health Information

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

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

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

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

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

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

- **Lawsuits and legal actions**: We may share information about you in response to a court or administrative order, or in response to a subpoena.
- **Research**: We can use or share your information for certain research projects that have been evaluated and approved through a process that considers a patient's need for privacy.

We may contact you in the following situations

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

Your Rights That Apply To Your Health Information

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

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

Your Authorization

Except as outlined above, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization.

Contact Information
Sanford Health Plan
Customer Service Department
PO Box 91110
Sioux Falls, SD 57109-1110
(800) 752-5863 (toll-free) | TTY/TDD (877) 652-1844 (toll-free)

Our Responsibilities Regarding Your Health Information

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

Changes to This Notice

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

Effective Date

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

Notice of Organized Health Care Arrangement for Sanford Health Plan

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

Advance Directives

We are required to tell our members about advance directive laws. An advance directive is a written instruction, such as a living will or health care power of attorney. It is law regarding the instructions you can write to tell your doctors and family what kind of care you want if you are too sick to make health care decisions on your own (i.e. a person who has suffered a head injury, is in a coma, a patient with advanced Alzheimer's disease, or a person in the last stages of cancer). The instructions are written and witnessed in advance of the possible need for the directives. Advance directives can provide peace of mind now and will protect your right to health care the way you want it.

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Utilization Management

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 at the end of this notice.

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:

1. Prospective Review (Pre-Service prior Authorization);
2. Concurrent Review; and
3. 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 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 (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.

The date of receipt for non-urgent requests received outside of normal business hours will be the next business day. The date of receipt for urgent requests will be the actual date of receipt, regardless of the hour. For *Minnesota Members*, any communication received after midnight Monday through Friday will be responded to on the same business day. All Utilization Management Adverse Determinations will be made by the Sanford Health Plan Chief Medical Officer or appropriate Practitioner. All benefit Adverse Determinations will be made by a person assigned to coordinate the benefit, Denial and Appeal process.

You are ultimately responsible for obtaining authorization (certification) from the Utilization Management Department. Failure to obtain certification will result in coverage at the reduced payment level. However, information provided by the Practitioner and/or Provider's office also satisfies this requirement. For *Minnesota Members*, failure to obtain Certification may result in coverage at the Reduced Payment Level. **(NOTE: For Plans with no Out-of-Network coverage, benefits are not payable when you fail to obtain certification).**

Medical Necessity

The Plan determines whether a service, treatment, technology, or prescription drug or supply (service) is Medically Necessary by applying the following criteria:

a. Must be consistent with generally accepted standards of medical practice as recognized by the Plan, as determined by health care practitioners in the same or similar specialty as typically manages the condition, procedure, or treatment or issue.
b. Help restore or maintain the member's health.
c. Be required for reasons other than the convenience of the covered person of his/her physician, or

solely for custodial, comfort, convenience, appearance, educational, recreational or vocational reasons.

d. Prevent deterioration of the member's condition.
e. Prevent the reasonably likely onset of a health problem or detect an incipient problem.
f. Not considered experimental or investigational unless part of an Approved Clinical Trial.

In compliance with the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), the criteria for medical necessity determinations is available upon request to any current or potential participant, beneficiary, or contracting provider.

Not all services prescribed or recommended by Plan physicians are necessarily covered by the Plan. The Plan's Chief Medical Officer or designee, using consultants as needed, makes the final determination of which services are covered by the Plan, in conjunction with the Member's Policy. For more information, visit the Member Rights section of sanfordhealthplan.com or contact Customer Service.

Prospective (Pre-service and Urgent Pre-service) Review of Services (Certification/Prior Authorization)

"Prospective Review" is the urgent or non-urgent review conducted prior to the provision of a health service. Prospective (Pre-service) review decisions are designed to facilitate early identification of the treatment plan to ensure medical management and available resources are provided throughout an episode of care.

"Certification" is a determination by the Plan that a request for a benefit has been reviewed and, based on the information provided, satisfies the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, and effectiveness.

Prior authorization is required for all inpatient admissions of Plan members. This requirement applies but is not limited to the following:

1. Acute care hospitalizations (including medical, surgical, obstetric, and non-emergency mental health or substance use disorder inpatient admissions);
2. Residential Treatment Facility admissions; and
3. Rehabilitation center admissions.

See *"Services that Require Prospective Review"* on the following pages.

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

For medical necessity requests, the Utilization Management Department will review Member profile information against standard criteria. For benefit determinations, a person assigned to coordinate the benefit, Denial and Appeal process will review the request against Plan Policy. Determinations and notifications of decisions to the Member and Practitioner and/or Provider are made within the timeframes required by state law and NCQA standards. Urgent Care Request determinations are made as soon as possible but no later than the timeframe 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

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determination. Please refer to your Policy. For more information, visit the Member Rights section of sanfordhealthplan.com or contact Customer Service.

Services that Require Prospective (Pre-service) Review and Certification:

1. Admissions.
2. Ambulance Services.
3. Clinical Trials.
4. Select Durable Medical Equipment (DME).
5. Home Health/Hospice services.
6. Implant Stimulators.
7. Oncology Services and Treatment.
8. Outpatient Services.
9. Outpatient Surgery.
10. Transplants.
11. Referrals to Non-Participating Providers, which are recommended by Participating Providers. Preauthorization/Prior Approval is required for the purposes of receiving In-Network level coverage. If Preauthorization/Prior Approval is not obtained for referrals to Non-Participating Providers, the services will be covered at the Out-of-Network level if your Plan has Out-Of-Network coverage. Preauthorization/Prior Approval does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers.

Please refer to your Policy for more information on certification requirements.

Urgent Care Requests

In determining whether a request is "Urgent," the Plan shall apply the judgment of a Prudent Layperson, as defined in your Policy. When a Practitioner with knowledge of the Member's medical condition determines a Member's condition to be an Urgent Care Situation, the Plan shall treat the Prospective Review as an Urgent Care Request. For more information, visit the Member Rights section at sanfordhealthplan.com or contact Customer Service.

Prospective (Pre-service) Review is not required for Emergency Conditions. However, if you are admitted, the Plan must be notified as soon as reasonably possible, and no later than *forty-eight (48)* hours, after you are physically or mentally able to do so. Additionally, because of the inability to predict admission, obstetrical admissions shall be certified when the pregnancy is confirmed. The exception is that of an elective C-section, which must be certified as an elective admission.

Concurrent Review

"Concurrent Review" is utilization review conducted during a Member's hospital stay or course of treatment in a facility or other inpatient or outpatient health care setting. It is utilized when a request for an extension of an approved ongoing course of treatment over a period of time or number of treatments

is warranted. Additional stay days must meet the continued stay review criteria and, if acute level of care criteria is not met, a decision to certify further treatment will be made at that time.

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. Urgent care request determinations are made as soon as possible but no later than the timeframe required by state law and NCQA standards. Please refer to your Policy for Sanford Health Plan's procedure for timely handling of concurrent review. For more information, visit the Member Rights section at sanfordhealthplan.com or contact Customer Service.

Retrospective Review (Post-service)

Retrospective Review means any review of a request for a benefit that is not a Prospective (Pre-service) Review request, which does not include the review of a claim that is limited to veracity of documentation, or accuracy of coding, or adjudication for payment. Retrospective (Post-service) Review will be utilized by Sanford Health Plan to review services that have already been utilized by the Member.

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. Please refer to your Policy for Sanford Health Plan's procedure for timely handling of Retrospective (Post-service) Review requests and for details on extensions for special circumstances. For more information, visit the Member Rights section at sanfordhealthplan.com or contact Customer Service.

Case Management

Sanford Health Plan provides nurse case management services to insured members in order to assist in controlling health care costs and improve the overall health of our Members. The Case Manager is the link between the individual, the practitioners and/or providers, the payer and the community. The Case Manager encourages appropriate use of medical resources and monitors effectiveness on a case-by-case basis. The Case Manager is an advocate for the Member as well as the payer to facilitate a win-win situation for the patient, the health care team and the payer.

For individuals with more complex health needs, the Nurse Case Manager is a resource and advocate for you by assisting you in understanding your condition and treatment plan. The Case Manager will work with you to develop personalized goals and a self-management plan so you feel more in control of your health. The Case Manager will also work directly with your care team to ensure your needs are met.

If you would like more information about this program, and whether you meet the criteria to participate in the program, please contact our Care Management Team toll-free at (888) 315-0884 | TTY/TDD: (877) 652-1844 (toll-free) or quality@sanfordhealth.org.

Discharge Planning

The Utilization Management Coordinator begins assessing discharge planning needs at the beginning of any hospital admission. The reviewer assists in the identification of Members with post hospital care needs for which social service and hospital discharge planning services would be appropriate. The

Utilization Management Coordinator can, with the advice and counsel of the attending Practitioner, work actively with social services and hospital discharge planning to assist in coordinating inter-hospital transfer, transfers to nursing homes, home health care, transportation, and any durable medical equipment needed.

Member Complaint and Appeal Procedures & Independent External Review Rights

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 Practitioners and/or Providers with knowledge of the Member's medical condition, authorized representative of the Member and/or an attorney may request a review of any Adverse Determination by Sanford Health Plan. The Member or his/her legal guardian may designate in writing to Sanford Health Plan an authorized representative to act on his/her behalf. This written designation of representation from the Member is needed by the Plan to communicate with an Authorized Representative.

To obtain additional information on the following complaint and appeal procedures, visit the Member Rights section at sanfordhealthplan.com or contact Customer Service toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844.

Definitions

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

Complaint: An oral or written expression of dissatisfaction. It is the policy of Sanford Health Plan to make reasonable efforts to resolve Member and Practitioner and/or Provider Complaints.

Urgent Care Situation: A degree of illness or injury which is less severe than an Emergency Condition, but requires prompt medical attention within 72-hours (24-hours for South Dakota and Minnesota members). An Urgent Care Request means a request for a health care service or course of treatment with respect to which the time periods for making a non-Urgent Care
Request determination could:

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

A Prudent Layperson is a person who is without medical training and who draws on his or her practical experience when making a decision regarding the need to seek Emergency medical treatment

Appeals: Means a request to change a previous Adverse Determination made by Sanford Health Plan.

Adverse Determination: Means a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to

provide or make payment that is based on:

1. A determination of an individual's eligibility to participate in a plan;
2. A determination that a benefit is not a Covered Benefit;
3. The imposition of a source-of-injury exclusion, network exclusion, application of any utilization review, or other limitation on otherwise covered benefits;
4. A determination that a benefit is Experimental, Investigational or not Medically Necessary or appropriate; or
5. A rescission of coverage. For *Minnesota Members*, only an act, practice, or omission that constitutes fraud or intentional misrepresentations of material fact, made by an applicant for health insurance coverage may be used to void application or policy and deny claims.

The types of Adverse Determinations (*denials*) above are eligible for the Appeal process in Iowa, North Dakota, and South Dakota. *Minnesota Members*, see *Appeal Procedures for Minnesota Members*.

Utilization Review: Means the evaluation of the necessity, appropriateness, and facilities used by a Member for the purpose of determining medical necessity of the service or admission.

Audit Trails: Audit trails for Complaints, Adverse Determinations and Appeals are provided by the Plan's information system and an Access database which includes documentation of the Complaints, Adverse Determinations and/or Appeals by date, service, procedure, substance of the complaint/appeal (including any clinical aspects/details), and reason for the complaint/adverse determination/appeal. The Appeal file includes telephone notification, and documentation 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 Adverse Determination and reason for determination, as well as any actions taken. If the Plan indicates authorization (Certification) by use of a number, the number must be called the "author4ization number."

External Review: An External Review is a request for an Independent, External Review of an adverse determination made by Sanford Health Plan through its External Review process.

Complaint Procedure

A Member may register a complaint by calling Customer Service toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844 (toll-free). If the Member's complaint cannot be resolved through a telephone call, the Plan will provide them with a Complaint form to complete and return to Customer Service; upon request, Customer Service will provide assistance in submitting a complaint. *Minnesota Members* may also contact your state regulator at any time to file a complaint about Sanford Health Plan or about health care providers. Call the Minnesota Department of Health at (651) 201-5100 or (800) 657-3916.

Complaint and Appeal decisions and notifications of decisions to the Member and Practitioner and/or Provider are made by the Plan within the timeframes required by State law and NCQA standards. Please refer to the Member's Policy, the Notice of Adverse Determination, and the Member Rights section at sanfordhealthplan.com for the Plan's procedure for timely handling of Complaints and Appeals, how to initiate the Complaint and Appeal process, and the Member's rights to an independent External Review. You may also contact Customer Service. For *Minnesota Members*, at any time, the complainant may also file a Complaint with the Commissioner of Health regarding network benefits, either in writing or by calling (651) 201-5100, or toll-free (800) 657-3916 or the Commissioner of Commerce regarding supplemental (Out-of-Network) benefits at (651) 296-2488, or toll-free at (800) 657-3602.

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Right to Civil Action

If you remain dissatisfied with Sanford Health Plan's determination after completing the required appeals process, you may have the right to file a civil action suit under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

Appeal Procedures for **IOWA**, **NORTH DAKOTA**, and **SOUTH DAKOTA** Members

In Iowa, North Dakota, and South Dakota appeals must be submitted within *one hundred eighty* (180) days after the date of receipt of a notice of an Adverse Determination.

Types of Appeals

- A **Pre-service appeal** is a request to change an Adverse Determination that Sanford Health Plan approved in whole or in part in advance of the Member obtaining care or services.
- A **Post-service appeal** is a request to change an Adverse Determination for care or services already received by the Member. This includes appeals related to coverage and medical necessity decisions as well as appeals related to the outcome of a complaint.
- An **Expedited Appeal for Urgent Care** is a request to change a previous Adverse Determination made by Sanford Health Plan for an Urgent Care Request. If the Member's situation meets the definition of urgent, their review will be conducted within 72-hours (24-hours for South Dakota members).
- An External Review is a request for an independent, External Review of a medical necessity final determination made by Sanford Health Plan through its External Appeals process.

Pre-service (Prior Authorization) Appeal Process

If Sanford Health Plan has declined to provide benefits, in whole or in part, for the requested treatment or service, or if the Member believes the determination was made in error, the Member has the right to appeal. An appeal may be requested by a Member, his or her authorized representative, practitioner or Provider by writing or calling Customer Service toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844 (toll-free), if the determination for a request for service was adverse to the Member. The Member's Appeals Rights are included in the Member's initial Notice of Adverse Determination. Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the appeal in writing or electronically within thirty (30) calendar days of receipt of Appeal.

Post-service Appeal Process

If any Member or authorized representative as designated in writing by the Member acting on behalf of the Member, has a question, complaint or other problem regarding claims payment for a Post-service(s) or those services already received, any aspect of the Plan's services, his or her relationship with the Plan and its Practitioners and/or Providers other than a complaint regarding certification, or authorization decision, the Member or the authorized representative should contact the Plan by calling or sending a written complaint to the following address:

Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110
Phone: (800) 752-5863 (toll-free) | TTY/TDD: (877) 652-1844 (toll-free)

The Member or Authorized Representative may also submit an appeal by logging into their account at sanfordhealthplan.com using the *Ask a question* feature. Sanford Health Plan will notify the Member or their Authorized Representative and any Practitioner and/or Providers involved in the appeal in writing or

electronically within sixty (60) calendar days of receipt of Appeal for SD and ND Members, within thirty (30) calendar days of receipt of Appeal for IA Members.

Expedited Appeal for Urgent Care Process

If the Member's situation meets the definition of urgent under the law, the Member's review will generally be conducted within 72-hours (24-hours for South Dakota members). Generally, an urgent situation is one in which the Member's health may be in serious jeopardy, or in the opinion of their physician, the Member may experience pain that cannot be adequately controlled while waiting for a decision on an appeal. If the situation is urgent, an expedited appeal may be requested by contacting us toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844 (toll-free). A simultaneous external review may also be filed with your state's Insurance Department: In South Dakota, contact (605) 773-3563; in Iowa, contact (877) 955-1212; and in North Dakota, contact (800) 247-0560. For more information, visit the Member Rights section at sanfordhealthplan.com or contact Customer Service.

If the expedited review is a Concurrent Review determination, the service must be continued without liability to the Member until the Member or the representative has been notified of the determination.

Continued Coverage for Concurrent Care during an Appeal

A Member is entitled to continued coverage for concurrent care pending the outcome of the appeals process; benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice sufficient to allow the claimant to appeal and obtain a review determination before the benefit is reduced or terminated. Review determinations would be made within 24 hours.

External Review Process

The Plan will follow the procedure for providing independent, external review of final determinations as outlined by the Affordable Care Act. Accordingly, an Independent External Review is not available for Benefit Adverse Determinations. Information on how to initiate an External Review request is included in the final Notice of Adverse Determination as well as in the Member's Policy. For more information, visit the Member Rights section at sanfordhealthplan.com or contact Customer Service.

Appeal Procedures for **MINNESOTA** Members

Types of Adverse Determinations (Denials)

1. Benefits Adverse Determination – a denial that is specifically excluded from the Member's benefits package and is not considered Medical Necessity.
2. Medical Necessity Adverse Determination – a denial of care of services that could be considered a covered benefit depending on the circumstances.
3. Claims Adverse Determination – denials based on timely and accurate filing of claims and failure to request prior authorization of services for out-of-network services.

Pre-Service Appeal (for Utilization Review for a medical determination)

An appeal may be requested by a Member, his or her authorized representative, practitioner or Provider by writing or calling Customer Service toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844 (toll-free), if the determination for a request for service was adverse to the Member.

If the Member or a Member's Authorized Representative Appeals an adverse determination, Members do not have the right to attend or have a representative attend the review, but Members are entitled to:

1. Send written comments, documents, records and other material relating to the request; and

2. Receive reasonable access to documents, records and other information relevant to the request, free of charge.
3. Confirm whether additional information will be provided for appeal review. The Plan will document if additional information is provided or no new information is provided for appeal review.

When an initial adverse determination is to deny your request, you or your Authorized Representative may submit a request for Appeal. If the request concerns non-urgent services, a written decision on your Complaint will be made to you and your Practitioners and/or Providers involved in the Appeal within *thirty (30) calendar days* from the date the Plan receives your request.

Expedited Internal Appeal Procedure

An Expedited Appeal procedure is used when the condition is emergent or urgent in nature. An Expedited Appeal of a prior authorization (Pre-service) Denial must be utilized if the Member or Practitioner acting on behalf of the Member believes that the request is warranted (per MN Statute 62M.05 subd. 3b). This can be done by oral or written notification to the Plan.

The determination will be made and provided to the Member and those Practitioners and/or Providers involved in the Appeal via telephone by the Utilization Management Department as expeditiously as the Member's medical condition requires but no later than within *seventy-two (72) hours* of receipt of the request. The Member and those Practitioners and/or Providers involved in the Appeal will receive written notification within *three (3) calendar days* of the telephone notification.

If the Expedited Review is a Concurrent Review determination, the service must be continued without liability to the Member until the Member or the Representative has been notified of the determination.

Post-Service Internal Appeal

If after the initial adverse determination review of a Post-service claim your request was denied, you or your Authorized Representative may submit a request for Appeal either in writing or by telephone. Additional information may be provided for appeal review.

Written requests should include any relevant documents, issues, comments and additional information as appropriate and be sent to:

Sanford Health Plan of Minnesota
Customer Service Department
PO Box 91110
Sioux Falls, SD 57109-1110

The Customer Service Department will provide the complainant with the option of either a written reconsideration, or a hearing (MN 62Q.70 Subd.2) before the Member Appeals Committee either in person or over the telephone. During your Appeal, upon your 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 complainant within *thirty (30) calendar days* of the Customer Service Department's receipt of the complainant's written notice of Appeal. If a complainant Appeals by hearing, written notice of the decision and all key findings will be given to the complainant within *forty-five (45) calendar days* of the Customer Service Department's receipt of the complainant's written notice of Appeal.

Independent, External Review of Final Adverse Determinations (Denials)

1. If your request 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 request. There are no external appeal rights for adverse determinations related to benefit decisions. If your request is denied for any other reason, you have the right to request External Review upon notice of our decision at the completion of the internal Appeal process.
2. To initiate the External Review process, you, or anyone acting on your behalf must complete an external review form and submit the written request to:
   Minnesota Department of Health
   Managed Care Systems Section
   PO Box 64882
   St. Paul, MN 55164-0882
   (651) 201-5100 or (800) 657-391Email: health.mcs@state.mn.us
3. The request for an independent, external review of final determinations must be filed within six (6) months of the date that the Plan's Adverse Determination was made.
4. This written request must be accompanied by a $25 filing fee payable to Minnesota Department of Health. This fee may be waived by the Minnesota Department of Health in cases of financial hardship. The Plan must participate in this External Review, and must pay the cost of the review which exceeds the $25 filing fee.
5. Upon receipt of the request for External Review, the external reviewer must provide immediate notice of the review to the complainant and to the Plan. Within *ten (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.
6. An External Review must be made as soon as possible, but no later than *forty (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, and to the Plan.
7. The results of the External Review are non-binding on the Member and binding on the Plan. The Plan may seek judicial review of the decision under certain circumstances.
8. Notification to Members about the Independent, External Appeal program includes a general communication to Members, at least annually, to announce the availability of the right to Independent, External Review.

Special Communication Services

The Plan provides interpreter services to assist members who speak a language other than English. The plan also provides help for Members who are hearing or vision-impaired. Special communication services are provided at no cost to the Member.

Once an interpreter is contacted, a three-way conversation will take place between the Member, Plan representative and the interpreter. All communication services provided through interpreters are confidential and free of charge to the Member. Visually impaired Members may contact Customer Service toll-free at (800) 752-5863 | TTY/TDD: (877) 652-1844 *(toll-free)* to request large-print or audio versions of the Plan's documents and Member materials. For Members who have trouble reading Plan

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documents, or understanding written Member materials, Plan representatives can read information to Members over the phone.

Hearing-impaired Members wishing to contact the Plan may call toll-free at TTY/TDD: (877) 652-1844. This number will connect Members to all staff/departments within the Plan (For example, Customer Service, Utilization Management, or Case Management).

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

Disclosure of Grandfather Status

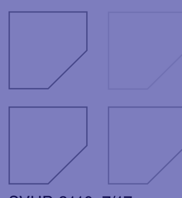
This section only applies to Members on a Grandfathered Heatlh Plan. Please refer to your Policy and coverage terms.

This employer group health plan is a “grandfathered health plan” under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a health plan considered “grandfathered” can keep certain basic health coverage that was in effect when that law was enacted. Being a grandfathered health plan means, your plan does not have to include certain consumer protections of the Affordable Care Act that apply to other plans. However, grandfathered health plans do have to comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits and requirements under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA). Additionally, Sanford Health has chosen to adopt some of the consumer protections of the Affordable Care Act. For example, effective October 1, 2010, Sanford Health Plan began covering federally recommended preventive health care services without any cost to you.

Questions regarding grandfathered health plan status can be emailed to our Customer Service Team at memberservices@sanfordhealth.org. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or dol.gov/ebsa/healthreform. The Department of Labor website has a table summarizing which protections do and do not apply to grandfathered health plans.

Preventive Health Guidelines

SANFORD HEALTH PLAN



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Preventive health guidelines and other screenings

Your health is very important to us and requires a key step from you: stay up-to-date on your preventive care! We believe that health promotion and disease prevention are valuable tools in the detection and treatment of preventable illnesses.

Take advantage of these services.

- No prior authorization is required when using an in-network provider
- Services are available at no cost to you
- Annual services do not need to be scheduled 12 months apart – you may have your preventive services one time per calendar year

For questions regarding your benefits, please contact our Member Services Team at (800) 752-5863. For TTY/TDD, call toll-free (877) 652-1844. If you need us to translate this letter, please call (800) 892-0675. This is a free service.

Important note:

- Services performed outside of these guidelines and with a medical diagnosis will be applied to your deductible and coinsurance.
- These services are provided to you as listed, unless otherwise stated in your plan document (i.e. Summary Plan Description/Policy/Certificate of Insurance).

Child and adolescent

Screening/prevention	Age	Benefit
Anemia screening	0-18 years	Allowed once per calendar year – hemoglobin or hematocrit test
Autism screening	18-24 months	Allowed in office setting during preventive exam only
Cholesterol screening	0-18 years	Allowed twice between ages indicated
Dental Cavities Prevention - Fluoride treatment	0-6 years	Allowed application of fluoride varnish to the primary teeth in a primary care office setting during preventive exam only
	6 months and older	Allowed as oral fluoride supplements for children whose water supply is fluoride deficient
Depression screening	11-18 years	Allowed in office setting during preventive exam only
Developmental screening	9, 18 and 30 months	Allowed in office setting during preventive exam only (with validated tool)
Hearing/vision screening	0-18 years	Allowed in an office setting during preventive exam only, once per calendar year
Hepatitis B virus screening	0-18 years	Allowed for at risk members
Immunizations		For a list of covered immunizations, please visit: www.cdc.gov/vaccines or call Member Services at (800) 752-5863
Iron supplements	6-12 months	Allowed for children at risk for iron deficiency anemia
Lead screening	12 & 24 months	Allowed once at each age indicated
Neonatal screenings	Newborn	All government mandated neonatal screenings tests and treatments including but not limited to: screening for hearing loss, hypothyroidism, PKU, congenital heart disease, bilirubin and sickle cell anemia
Obesity screening and counseling	6 years and older	Allowed as needed with referral to comprehensive, intensive behavioral interventions to promote improvement in weight status
Sexually Transmitted Disease screening	11-18 years	Allowed as counseling and screening for all at risk adolescents (includes chlamydia, gonorrhea, syphilis and HIV) at each exam
HIV screening	15-18 years	Allowed once for at risk members
Tuberculosis screening	0-18 years	Allowed as needed upon positive screening questions
Well child office visits - Under 3 years of age	3 to 5 days old and at 1, 2, 4, 6, 9, 12, 15, 18, 24 and 30 months	Allowed once for each age indicated. Visit to include information on development, behavior, safety and injury prevention, sleep positions, feeding and diet, daily care, physical activity, dental care, weight and length and head circumference (if applicable). Screening for socio-economic health, caregiver/maternal depression, social determinants of health, dental home and dental risk assessment.
Well child visits - 3+ years of age	3 years and older	Allowed once per calendar year. Visit to include information on height and weight, Body Mass Index (BMI), blood pressure, dental care, exercise and physical activity, diet and nutrition, counseling for obesity, sun exposure and safety and injury prevention. When appropriate, the following will be addressed/screened for: alcohol use, sexual behavior and Sexually Transmitted Diseases, education and brief counseling on tobacco use in school aged children and adolescents, suicide prevention, socio-economic health, caregiver depression, social determinants of health, dental home and dental risk assessment and drug education. For ages 3 to 5 years of age, a vision screening using the Snellen Eye Chart is allowed

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Adult

Screening/prevention	Age	Benefit
Abdominal aortic aneurysm screening	Men only: ages 65-75	Allowed one ultrasound screening per lifetime for males who have smoked
Anemia screening	18 and older	Allowed one per calendar year - Hemoglobin or Hematocrit test
Aspirin to prevent cardiovascular disease	50-59	Allowed for members at risk for developing cardiovascular disease
Basic Metabolic Panel	18 and older	Allowed one per calendar year
Cholesterol screening for men and women	18 and older	Allowed once for member between ages 18-24 Allowed one every 5 years for members age 25-44 Allowed one per calendar year for members age 45 and over NOTE: Additional tests, such as comprehensive metabolic panels will be applied to your deductible/coinsurance.
Colorectal cancer screening	50 and older	Allowed once every 10 years – colonoscopy (includes tissue sample analysis and anesthesia charges) **OR** Allowed once every 5 years – flexible sigmoidoscopy. **OR** Allowed once every 3 years – stool DNA test **OR** Allowed once every year - fecal occult blood/fecal immunochemical test (FIT) NOTE: Colonoscopy expenses due to a medical condition will be applied to your deductible/coinsurance, unless otherwise specified.
Diabetes screening	40 to 70	Allowed as blood sugar testing to screen for diabetes in adults as part of a cardiovascular risk assessment
Falls prevention in older adults: Exercise or physical therapy	65 and older	Allowed as exercise or physical therapy to prevent falls for members at increased risk for falls
Falls prevention in older adults: Vitamin D supplement	65 and older	Allowed for members at risk for falls
Hepatitis B Virus infection screening	18 and older	Allowed for at risk adults
Hepatitis C Virus (HCV) infection screening	18 and older	Allowed once lifetime for members born between 1945-1965 OR Allowed once per lifetime for members at risk
Immunizations		For a list of covered immunizations, please visit: www.cdc.gov/vaccines or call Member Services at (800) 752-5863
Lung cancer screening	55-80 years	Allowed once per calendar year for members: with a 30 pack-year smoking history, who currently smoke, or have quit smoking within the past 15 years
Prostate Specific Antigen (PSA)	Men only:50 and older	Allowed once per calendar year for men over age 50 if indicated after discussion with a physician
Sexually Transmitted Disease screening	18 and older	Allowed as counseling and screening (includes chlamydia, gonorrhea, syphilis and HIV) for all at risk adults at each exam
Tuberculosis Screening	18 and older	Allowed for adults at risk
Wellness exam	18 and older	Allowed as once per calendar year. Exam includes health advice and counseling on blood pressure, counseling and interventions on tobacco use, screening and counseling for alcohol use, sun exposure, screening for depression, obesity screening and behavioral interventions for patients with a body mass index of 30 or higher and referrals to intensive behavioral counseling to promote a healthful diet and physical activity to decrease cardiovascular risk in adults that are overweight or obese and with cardiovascular disease risk factors

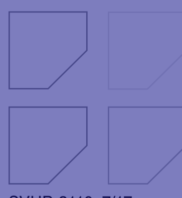
Women's health

Screening/prevention	Age	Benefit
Anemia screening		Allowed for pregnant women
Bacteriuria screening		Allowed in pregnant women at 12 to 16 weeks gestation or at the first prenatal visit, if later
Breast cancer preventive medications		Allowed for women at increased risk for breast cancer
Breast cancer screening	40 and older	Allowed once per calendar year for women
Breastfeeding supplies, support and counseling		Allowed one breast pump (electric or manual, nonhospital grade) per pregnancy along with replacement tubing, breast shields, and splash protectors are covered when obtained from a Sanford Health Plan contracted durable medical equipment provider. Consultations with a lactation (breastfeeding) specialist are also covered
Cervical cancer screening	21-65 years	Allowed one Pap smear testing every 3 years for women 21 to 29 years of age **OR** Allowed one Pap smear testing every 3 years or once every 5 years if HPV test performed for women age 30 to 65 years of age
Counseling and interventions to prevent tobacco use		Allowed for all pregnant women that use tobacco products
Family planning		Allowed for select barrier methods, intrauterine devices, sterilization and contraceptives as listed on the formulary. For specific information, contact Member Services at (800) 752-5863
Folic acid supplements		Allowed for women planning to become pregnant or in their childbearing years
Genetic counseling and evaluation for BRCA Testing and BRCA lab screening		Allowed for women who have family members with breast, ovarian, tubal, or peritoneal cancer with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (BRCA1 or BRCA2). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing
Gestational diabetes screening		Allowed for all pregnant women after 24 weeks gestation
Hepatitis B virus infection screening		Allowed for all pregnant women
HPV testing	30 and older	Allowed for women over age 30 years old
Intimate partner violence screening		Allowed for women of childbearing age and referral for women with a positive screening to intervention services
Osteoporosis screening	65 and older	Allowed once per lifetime for women age 65 and older or younger women if at increased risk for fractures
Preeclampsia prevention		Allowed for pregnant women with high risk for preeclampsia that are 12+ weeks gestation
Rh incompatibility screening		Rh blood typing allowed if biological father is unknown
Sexually Transmitted Disease screening		Allowed as counseling and screening (includes chlamydia, gonorrhea, syphilis and HIV) for all pregnant women
Tuberculosis Screening	18 and older	Allowed for adults at risk

*Please note: These services are provided as listed, unless your plan document (SPD/COC) states otherwise.

Pharmacy Handbook

SANFORD HEALTH PLAN



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Pharmacy Handbook

for Sanford Sioux Falls & non-grandfathered large group members

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Formulary

The formulary is a list of FDA-approved brand name and generic medications chosen by health care providers on the Physician Quality Committee. The Committee chooses medications that are clinically effective, safe, and cost-effective. Changes may be made throughout the year as warranted with a complete evaluation each year. Sanford Health Plan will publish these changes and notify you if any of the formulary changes impact your cost sharing or accessibility. By logging into your *my*SanfordHealthPlan account at sanfordhealthplan.com/memberlogin, you can find additional information, including a complete listing of the formulary, pharmacy locator, generic substitution information, side effects and interactions, and other benefit information.

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 medication cost in full.
4. Approved by the Federal Food and Drug Administration (FDA) for use in the United States.

This information about the formulary applies only to those medications that may be covered under this policy. By following the formulary, and asking your healthcare practitioner for generic medications, 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.**

Pharmacy Programs

Please review the following information concerning specialty medications, step therapy, certification, limited and non-covered services, the medication exclusion list, compounded medications, and quantity limits. If you have any questions or concerns, contact our Pharmacy Management Team toll-free at (855) 305-5062.

Specialty Medication Program

Sanford Health Plan has contracted with Accredo for specialty medications. Accredo will ship your medication and any supplies you may need directly to your home or 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 your copay for your medication and arrange delivery.

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

- Your name and date of birth
- Your phone number and address
- The name of your medication to be filled
- Your doctor's name and phone number

Accredo will mail a letter to your doctor explaining the program and how to send your prescription orders 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 condition the medication is treating.
- Medication refill 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.

The following medications may be obtained two different ways:

- from Accredo by calling (866) 333-9721; or
- from an approved retail pharmacy or practitioner's office.

It is important to obtain approval (certification) before filling a prescription for these medications. If these medications are obtained from a non-participating pharmacy or a practitioner's office without prior approval by the Pharmacy Management Department, the Member may be responsible for the full cost of the medication. The medications on this list covered under the medical benefit are subject to your deductible/coinsurance; and the medications covered under the pharmacy benefit are subject to a copay.

To obtain certification or determine how the medications on this list will be covered, contact the Pharmacy Management Team at (855) 305-5062/ TTY/TDD: (877) 652-1844.

Some medications listed below are subject to step therapy. Contact Pharmacy Management for details.

Medication name	Disease state/category	Coverage	Preferred alternatives
8-MOP	SKIN PREPS	MEDICAL	
ABRAXANE	CANCER	MEDICAL	
ACTEMRA IV	IMMUNOSUPPRESSANT	MEDICAL	
ACTEMRA Subcutaneous	IMMUNOSUPPRESSANT	PHARMACY TIER 3, Step Therapy Rules Apply	ENBREL, HUMIRA- Tier 2
ACTHAR H.P.	HORMONES	MEDICAL	
ACTIMMUNE	CANCER	MEDICAL	
ADCETRIS	CANCER	MEDICAL, Limited Distribution	
ADCIRCA	CARDIOVASCULAR	PHARMACY TIER 3	
ADEMPAS	CARDIOVASCULAR	PHARMACY TIER 3	
ADRUCIL	CANCER	MEDICAL	
ADVATE	HEMOPHILIA	MEDICAL	
AFINITOR	CANCER	MEDICAL	
ALDURAZYME	ENZYME DEFICIENCIES	MEDICAL	
ALFERON N	CANCER	MEDICAL	
ALIMTA	CANCER	MEDICAL	
ALKERAN	CANCER	MEDICAL	
ALPHANATE	HEMOPHILIA	MEDICAL	
ALPHANINE SD	HEMOPHILIA	MEDICAL	
ALPROLIX	HEMOPHILIA	MEDICAL	
AMEVIVE	INFLAMMATORY CONDITIONS	MEDICAL	
AMIFOSTINE	CANCER	MEDICAL	
AMPYRA	MULTIPLE SCLEROSIS	PHARMACY TIER 3	
APOKYN	ANTIPARKINSONS	PHARMACY TIER 3	
ARALAST NP	RESPIRATORY CONDITIONS	MEDICAL	
ARANESP	BLOOD CELL DEFICIENCY	PHARMACY TIER 2	
ARCALYST	INFLAMMATORY CONDITIONS	MEDICAL	
AREDIA	BONE CONDITIONS	MEDICAL	
ARESTIN	ANTIINFECTIVES	PHARMACY TIER 3	
ARRANON	CANCER	MEDICAL	
ARZERRA	CANCER	MEDICAL	
ATGAM	IMMUNE DEFICIENCY	MEDICAL	
AUBAGIO	MULTIPLE SCLEROSIS	PHARMACY TIER 2, Step Therapy Rules Apply	AVONEX, COPAXONE, REBIF, EXTAVIA, PLEGRIDY – Tier 2
AVASTIN	CANCER	MEDICAL	
AVONEX	MULTIPLE SCLEROSIS	PHARMACY TIER 2	
AZACITIDINE	CANCER	MEDICAL	
BEBULIN	HEMOPHILIA	MEDICAL	
BENEFIX	HEMOPHILIA	MEDICAL	
BENLYSTA	SYSTEMIC LUPUS ERYTHEM.	MEDICAL	
BERINERT	HEREDITARY ANGIOEDEMA	MEDICAL	
BEXXAR	CANCER	MEDICAL, Limited Distribution	
BICNU	CANCER	MEDICAL	
BIVIGAM	IMMUNE DEFICIENCY	MEDICAL	
BLEOMYCIN SULF	CANCER	MEDICAL	
BOSULIF	CANCER	MEDICAL	
BOTOX	NEUROMUSCULAR	MEDICAL	
BRAVELLE	INFERTILITY	100% Member Responsibility	
BUSULFEX	CANCER	MEDICAL	
CALCIUM FOLINATE	CANCER	MEDICAL	
CAMPTOSAR	CANCER	MEDICAL	
CAPECITABINE	CANCER	MEDICAL	
CARBAGLU	GENETIC DISORDER	MEDICAL	
CARBOPLATIN	CANCER	MEDICAL	
CARIMUNE NF	IMMUNE DEFICIENCY	MEDICAL	
CAYSTON	ANTIBIOTICS	PHARMACY TIER 3, Limited Distribution	
CELLCEPT	IMMUNOSUPPRESSANT	MEDICAL	
CEPROTIN	BLOOD	MEDICAL	
CEREDASE	ENZYME DEFICIENCIES	PHARMACY TIER 3	

Medication name	Disease state/category	Coverage	Preferred alternatives
CEREZYME	ENZYME DEFICIENCIES	MEDICAL	
CERUBIDINE	CANCER	MEDICAL	
CETROTIDE	HORMONES	MEDICAL	
CHENODAL	INFLAMMATORY CONDITIONS	PHARMACY TIER 3, Limited Distribution	
CHORIONIC GONADOTROPIN	INFERTILITY	100% Member Responsibility	
CIMZIA	INFLAMMATORY CONDITIONS	PHARMACY TIER 3, Step Therapy Rules Apply	ENBREL, HUMIRA- Tier 2
CINRYZE	HEREDITARY ANGIOEDEMA	MEDICAL	
CISPLATIN	CANCER	MEDICAL	
CLADRIBINE	CANCER	MEDICAL	
CLOLAR	CANCER	MEDICAL	
COPAXONE	MULTIPLE SCLEROSIS	PHARMACY TIER 2	
COPEGUS	HEPATITIS C	PHARMACY TIER 3	
CORIFACT	HEMOPHILIA	MEDICAL	
COSENTYX	INFLAMMATORY CONDITIONS	PHARMACY TIER 2, Step Therapy Rules Apply	ENBREL, HUMIRA- Tier 2
COSMEGEN	CANCER	MEDICAL	
CYCLOPHOSPHAMIDE	CANCER	MEDICAL	
CYCLOSPORINE	IMMUNOSUPPRESSANT	MEDICAL	
CYSTAGON	MISCELLANEOUS SPECIALTY	PHARMACY TIER 2, Limited Distribution	
CYTARABINE	CANCER	MEDICAL	
CYTOGAM	IMMUNE DEFICIENCY	MEDICAL	
DACARBAZINE	CANCER	MEDICAL	
DACOGEN	CANCER	MEDICAL	
DACTINOMYCIN	CANCER	MEDICAL	
DAUNORUBICIN HCL	CANCER	MEDICAL	
DAUNOXOME	CANCER	MEDICAL	
DDAVP	HORMONES	MEDICAL	
DECITABINE	CANCER	MEDICAL	
DEFEROXAMINE MESYLATE	IRON TOXICITY	MEDICAL	
DEPOCYT	CANCER	MEDICAL	
DESFERAL	IRON TOXICITY	MEDICAL	
DESMOPRESSIN ACETATE	HORMONES	MEDICAL	
DOCEFREZ	CANCER	MEDICAL	
DOCETAXEL	CANCER	MEDICAL	
DYSPORT	NEUROMUSCULAR	MEDICAL	
ELAPRASE	ENZYME DEFICIENCIES	MEDICAL	
ELELYSO	ENZYME DEFICIENCIES	MEDICAL, Limited Distribution	
ELIGARD	CANCER	MEDICAL	
ELITEK	ANTIARTHRITICS	MEDICAL	
ELLENCE	CANCER	MEDICAL	
ELOCTATE	HEMOPHILIA	PHARMACY TIER 3	
ELOXATIN	CANCER	MEDICAL	
ELSPAR	CANCER	MEDICAL	
ENBREL	INFLAMMATORY CONDITIONS	PHARMACY TIER 2	
enoxaparin sodium	ANTICOAGULANTS	PHARMACY TIER 1, available through retail	
ENTYVIO	INFLAMMATORY CONDITIONS	PHARMACY TIER 3, Step Therapy Rules Apply	ENBREL, HUMIRA - Tier 2
EPIRUBICIN HCL	CANCER	MEDICAL	
EPOGEN	BLOOD CELL DEFICIENCY	PHARMACY TIER 3	
EPOPROSTENOL SOD	CARDIOVASCULAR	MEDICAL	
ERBITUX	CANCER	MEDICAL	
ERIVEDGE	CANCER	MEDICAL	
ERWINAZE	CANCER	MEDICAL	
ESBRIET	RESPIRATORY CONDITIONS	PHARMACY TIER 3	
ETHYOL	CANCER	MEDICAL	
ETOPOPHOS	CANCER	MEDICAL	
ETOPOSIDE	CANCER	MEDICAL	

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Medication name	Disease state/category	Coverage	Preferred alternatives
EUFLEXXA	ANTIARTHRITICS	MEDICAL	
EXJADE	IRON TOXICITY	MEDICAL	
EXTAVIA	MULTIPLE SCLEROSIS	PHARMACY TIER 2	
EYLEA	OPTHALMIC CONDITIONS	MEDICAL	
FABRAZYME	ENZYME DEFICIENCIES	MEDICAL	
FASLODEX	CANCER	MEDICAL	
FEIBA NF	HEMOPHILIA	MEDICAL	
FEIBA VH IMMUNO	HEMOPHILIA	MEDICAL	
FERRIPROX	IRON TOXICITY	PHARMACY TIER 3, Limited Distribution	
FIRAZYR	HEREDITARY ANGIOEDEMA	PHARMACY TIER 3	
FIRMAGON	CANCER	MEDICAL	
FLEBOGAMMA DIF	IMMUNE DEFICIENCY	MEDICAL	
FLOLAN	CARDIOVASCULAR	MEDICAL	
FLOXURIDINE	CANCER	MEDICAL	
FLUDARA	CANCER	MEDICAL	
FLUDARABINE PHOSPHATE	CANCER	MEDICAL	
FLUOROURACIL	CANCER	MEDICAL	
FOLLISTIM AQ	INFERTILITY	100% Member Responsibility	
FOLOTYN	CANCER	MEDICAL	
fondaparinux sodium	ANTICOAGULANTS	PHARMACY TIER 1, available through retail	
FORTEO	BONE CONDITIONS	PHARMACY TIER 2	alendronate - Tier 1
FRAGMIN	ANTICOAGULANTS	PHARMACY TIER 2, available through retail	enoxaparin, fondaparinux – Tier 1
FUSILEV	CANCER	MEDICAL	
FUZEON	ANTIVIRALS	MEDICAL	
GAMASTAN S-D	IMMUNE DEFICIENCY	MEDICAL	
GAMMAGARD LIQUID	IMMUNE DEFICIENCY	MEDICAL	
GAMMAGARD S-D	IMMUNE DEFICIENCY	MEDICAL	
GAMMAKED	IMMUNE DEFICIENCY	MEDICAL	
GAMMAPLEX	IMMUNE DEFICIENCY	MEDICAL	
GAMUNEX	IMMUNE DEFICIENCY	MEDICAL	
GAMUNEX-C	IMMUNE DEFICIENCY	MEDICAL	
GANIRELIX ACETATE	HORMONES	MEDICAL	
GATTEX	INFLAMMATORY CONDITIONS	MEDICAL	
GAZYVA	CANCER	MEDICAL	
GEL-ONE	ANTIARTHRITICS	MEDICAL	
GEMCITABINE HCL	CANCER	MEDICAL	
GEMZAR	CANCER	MEDICAL	
GILENYA	MULTIPLE SCLEROSIS	PHARMACY TIER 2, Step Therapy Rules Apply	AVONEX, COPAXONE, REBIF, EXTAVIA, PLEGRIDY – Tier 2
GILOTRIF	CANCER	MEDICAL	
GLASSIA	RESPIRATORY CONDITIONS	MEDICAL	
GLEEVEC	CANCER	MEDICAL	
GONAL-F/ RFF/ REDI-JECT	INFERTILITY	100% Member Responsibility	
GRANIX	BLOOD CELL DEFICIENCY	PHARMACY TIER 3	
HALAVEN	CANCER	MEDICAL	
HARVONI	HEPATITIS C	PHARMACY TIER 3, PA Required	PEGASYS, VIEKIRA - Tier 2
HELIXATE FS	HEMOPHILIA	MEDICAL	
HEMOFIL-M	HEMOPHILIA	MEDICAL	
HEPAGAM B	IMMUNE DEFICIENCY	MEDICAL	
HERCEPTIN	CANCER	MEDICAL	
HIZENTRA	IMMUNE DEFICIENCY	MEDICAL	
HUMATE-P	HEMOPHILIA	MEDICAL	
HUMATROPE	GROWTH HORMONE	PHARMACY TIER 2	
HUMIRA	INFLAMMATORY CONDITIONS	PHARMACY TIER 2	
HYALGAN	ANTIARTHRITICS	MEDICAL	
HYCAMTIN	CANCER	MEDICAL	
HYPERHEP B S-D	IMMUNE DEFICIENCY	MEDICAL	
HYPERRAB S-D	IMMUNE DEFICIENCY	MEDICAL	

Medication name	Disease state/category	Coverage	Preferred alternatives
HYPERRHO S-D	IMMUNE DEFICIENCY	MEDICAL	
IBANDRONATE SOD	BONE CONDITIONS	MEDICAL	
IDAMYCIN PFS	CANCER	MEDICAL	
IDARUBICIN HCL	CANCER	MEDICAL	
IFEX	CANCER	MEDICAL	
IFOSFAMIDE-/MESNA	CANCER	MEDICAL	
ILARIS	INFLAMMATORY CONDITIONS	MEDICAL	
IMOGAM RABIES-HT	IMMUNE DEFICIENCY	MEDICAL	
INCRELEX	HORMONES	MEDICAL	
INFERGEN	HEPATITIS C	PHARMACY TIER 3, PA Required	PEGASYS, VIEKIRA - Tier 2
INLYTA	CANCER	MEDICAL	
INTRON A	CANCER	MEDICAL	
IPRIVASK	ANTICOAGULANTS	PHARMACY TIER 3, available through retail	enoxaparin, fondaparinux – Tier 1, FRAGMIN - Tier 2
IRINOTECAN HCL	CANCER	MEDICAL	
ISTODAX	CANCER	MEDICAL	
IXEMPRA	CANCER	MEDICAL	
JAKAFI	CANCER	MEDICAL	
JEVTANA	CANCER	MEDICAL	
KADCYLA	CANCER	MEDICAL	
KALBITOR	HEREDITARY ANGIOEDEMA	MEDICAL	
KALYDECO	RESPIRATORY CONDITIONS	MEDICAL	
KEPIVANCE	INFLAMMATORY CONDITIONS	MEDICAL	
KINERET	ANTIARTHRITICS	PHARMACY TIER 3, Step Therapy Rules Apply	ENBREL, HUMIRA- Tier 2
KOATE-DVI	HEMOPHILIA	MEDICAL	
KOGENATE FS	HEMOPHILIA	MEDICAL	
KRYSTEXXA	ANTIARTHRITICS	MEDICAL	
KUVAN	PKU	MEDICAL	
KYNAMRO	CARDIOVASCULAR	MEDICAL	
KYPROLIS	CANCER	MEDICAL, Limited Distribution	
LETAIRIS	CARDIOVASCULAR	PHARMACY TIER 2	
LEUKINE	BLOOD CELL DEFICIENCY	MEDICAL	
LEUPROLIDE ACET	CANCER	MEDICAL	
LEUSTATIN	CANCER	MEDICAL	
LUCENTIS	OPTHALMIC CONDITIONS	MEDICAL	
LUMIZYME	ENZYME DEFICIENCIES	MEDICAL	
LUPANETA PACK	HORMONES	PHARMACY TIER 3	
LUPRON DEPOT	CANCER	MEDICAL	
LUPRON DEPOT-PED	HORMONES	MEDICAL	
MACUGEN	OPTHALMIC CONDITIONS	MEDICAL	
MEKINIST	CANCER	MEDICAL	
MELPHALAN HCL	CANCER	MEDICAL	
MENOPUR	INFERTILITY	100% Member Responsibility	
MESNA	CANCER	MEDICAL	
MESNEX	CANCER	MEDICAL	
methotrexate	CANCER	PHARMACY TIER 1	
MICRHOGAM PLUS	IMMUNE DEFICIENCY	MEDICAL	
MITOMYCIN	CANCER	MEDICAL	
MITOXANTRONE	CANCER	MEDICAL	
MODERIBA	ANTIVIRALS	PHARMACY TIER 2	
MONOCLATE-P	HEMOPHILIA	MEDICAL	
MONONINE	HEMOPHILIA	MEDICAL	
MONOVISC	ANTIARTHRITICS	MEDICAL	
MOZOBIL	BLOOD CELL DEFICIENCY	MEDICAL	
MUSTARGEN	CANCER	MEDICAL	
MYALEPT	HORMONES	PHARMACY TIER 3	
MYOBLOC	NEUROMUSCULAR	MEDICAL	
MYOZYME	ENZYME DEFICIENCIES	MEDICAL	
NABI-HB	IMMUNE DEFICIENCY	MEDICAL	
NAGLAZYME	ENZYME DEFICIENCIES	MEDICAL	
NAVELBINE	CANCER	MEDICAL	
NEULASTA	BLOOD CELL DEFICIENCY	PHARMACY TIER 3	

Medication name	Disease state/category	Coverage	Preferred alternatives
NEUMEGA	BLOOD CELL DEFICIENCY	MEDICAL	
NEUPOGEN	BLOOD CELL DEFICIENCY	PHARMACY TIER 2	
NEXAVAR	CANCER	MEDICAL	
NIPENT	CANCER	MEDICAL	
NOVAREL	INFERTILITY	100% Member Responsibility	
NOVOSEVEN	HEMOPHILIA	MEDICAL	
NOVOSEVEN RT	HEMOPHILIA	MEDICAL	
NPLATE	BLOOD CELL DEFICIENCY	MEDICAL	
NULOJIX	IMMUNOSUPPRESSANT	MEDICAL	
NUTROPIN	GROWTH HORMONE	PHARMACY TIER 2	
OCTAGAM	IMMUNE DEFICIENCY	MEDICAL	
OCTREOTIDE ACETATE	HORMONES	MEDICAL	
OFORTA	CANCER	MEDICAL	
OLYSIO	HEPATITIS C	PHARMACY TIER 3, PA Required	PEGASYS, VIEKIRA - Tier 2
OMONTYS	BLOOD CELL DEFICIENCY	PHARMACY TIER 3	
ONCASPAR	CANCER	MEDICAL	
ONSOLIS	ANALGESICS	PHARMACY TIER 3	
OPSUMIT	CARDIOVASCULAR	PHARMACY TIER 3	
ORALAIR	IMMUNE DEFICIENCY	PHARMACY TIER 3	
ORENCIA IV	ANTIARTHRITICS	MEDICAL	
ORENCIA SC	ANTIARTHRITICS	PHARMACY TIER 3, Step Therapy Rules Apply	ENBREL, HUMIRA- Tier 2
ORENITRAM ER	CARDIOVASCULAR	PHARMACY TIER 3	
ORTHOCLONE OKT-3	IMMUNOSUPPRESSANT	MEDICAL, Limited Distribution	
ORTHOVISC	ANTIARTHRITICS	MEDICAL	
OTEZLA	ANTIARTHRITICS	PHARMACY TIER 3, Limited Distribution, Step Therapy Rules Apply	ENBREL, HUMIRA - Tier 2
OVIDREL	INFERTILITY	100% Member Responsibility	
OXALIPLATIN	CANCER	MEDICAL	
OZURDEX	OPTHALMIC CONDITIONS	PHARMACY TIER 3	
PACLITAXEL	CANCER	MEDICAL	
PAMIDRONATE DISODIUM	BONE CONDITIONS	MEDICAL	
PANRETIN	CANCER	MEDICAL	
PEGASYS/PROCLICK/ REDIPEN	HEPATITIS C	PHARMACY TIER 3, PA Required	
PEG-INTRON	HEPATITIS C	MEDICAL	
PERJETA	CANCER	MEDICAL	
PHOTOFRIN	CANCER	MEDICAL	
PLEGRIDY	MULTIPLE SCLEROSIS	PHARMACY TIER 2	
POMALYST	CANCER	MEDICAL	
PRALUENT	ANTIHYPERLIPIDEMIC	PHARMACY TIER 3, PA Required	
PREGNYL	INFERTILITY	100% Member Responsibility	
PRIVIGEN	IMMUNE DEFICIENCY	MEDICAL	
PROCRIT	BLOOD CELL DEFICIENCY	PHARMACY TIER 2	
PROCYSBI	MISCELLANEOUS SPECIALTY	MEDICAL	
PROFILNINE SD	HEMOPHILIA	MEDICAL	
PROGESTERONE in OIL	INFERTILITY	100% Member Responsibility	
PROGRAF	IMMUNOSUPPRESSANT	INFUSION - MEDICAL ORAL - PHARMACY TIER 2	
PROLASTIN	RESPIRATORY CONDITIONS	MEDICAL	
PROLASTIN C	RESPIRATORY CONDITIONS	MEDICAL, Limited Distribution	
PROLEUKIN	CANCER	MEDICAL	
PROLIA	BONE CONDITIONS	PHARMACY TIER 3	alendronate - Tier 1
PROMACTA	BLOOD CELL DEFICIENCY	PHARMACY TIER 3	
PULMOZYME	RESPIRATORY CONDITIONS	PHARMACY TIER 3	
REBETOL	HEPATITIS C	PHARMACY TIER 2	
REBIF	MULTIPLE SCLEROSIS	PHARMACY TIER 2	
RECLAST	BONE CONDITIONS	MEDICAL	alendronate - Tier 1

Medication name	Disease state/category	Coverage	Preferred alternatives
RECOMBINATE	HEMOPHILIA	MEDICAL	
REFLUDAN	ANTICOAGULANTS	PHARMACY TIER 3, available through retail	enoxaparin, fondaparinux – Tier 1, FRAGMIN - Tier 2
REMICADE	INFLAMMATORY CONDITIONS	MEDICAL, Step Therapy Rules Apply	ENBREL, HUMIRA - Tier 2
REMODULIN	CARDIOVASCULAR	PHARMACY TIER 3	
REPATHA	ANTIHYPERLIPIDEMIC	PHARMACY TIER 3, PA Required	
REPRONEX	INFERTILITY	100% Member Responsibility	
RETROVIR	ANTIVIRALS	MEDICAL	
REVATIO	CARDIOVASCULAR	PHARMACY TIER 3	
REVLIMID	CANCER	MEDICAL	
RHOGAM PLUS	IMMUNE DEFICIENCY	MEDICAL	
RHOPHYLAC	IMMUNE DEFICIENCY	MEDICAL	
RIASTAP	BLOOD DISORDER	PHARMACY TIER 3	
RIBAPAK	HEPATITIS C	PHARMACY TIER 3	RIBAVIRIN - Tier 2
RIBASPHERE	HEPATITIS C	PHARMACY TIER 2	
RIBATAB	HEPATITIS C	PHARMACY TIER 3	RIBAVIRIN - Tier 2
RIBAVIRIN	HEPATITIS C	PHARMACY TIER 2	
RILUTEK	MISCELLANEOUS SPECIALTY	MEDICAL	
RITUXAN	CANCER	MEDICAL	
RIXUBIS	HEMOPHILIA	MEDICAL	
RUCONEST	HEREDITARY ANGIOEDEMA	PHARMACY TIER 3	
SABRIL	ANTICONVULSANT	PHARMACY TIER 3	
SANDIMMUNE	IMMUNOSUPPRESSANT	MEDICAL	
SANDOSTATIN	HORMONES	MEDICAL	
SIGNIFOR	HORMONES	MEDICAL	
sildenafil citrate	CARDIOVASCULAR	PHARMACY TIER 1	
SIMPONI	ANTIARTHRITICS	PHARMACY TIER 3, Step Therapy Rules Apply	ENBREL, HUMIRA- Tier 2
SIMPONI ARIA	ANTIARTHRITICS	PHARMACY TIER 3, Step Therapy Rules Apply	ENBREL, HUMIRA- Tier 2
SIMULECT	IMMUNOSUPPRESSANT	MEDICAL	
SIPULEUCEL-T PROVENGE	CANCER	MEDICAL	
SOLIRIS	BLOOD DISORDER	MEDICAL	
SOMATULINE DEPOT	HORMONES	PHARMACY TIER 3	
SOMAVERT	GROWTH HORMONE	PHARMACY TIER 3	
SOVALDI	HEPATITIS C	PHARMACY TIER 3, PA Required	
SPRYCEL	CANCER	MEDICAL	
STELARA	IMMUNOSUPPRESSANT	PHARMACY TIER 3, Step Therapy Rules Apply	ENBREL, HUMIRA- Tier 2
STIVARGA	CANCER	MEDICAL	
SUCRAID	INFLAMMATORY CONDITIONS	PHARMACY TIER 2	
SUPARTZ	ANTIARTHRITICS	MEDICAL	
SUPPRELIN LA	HORMONES	MEDICAL	
SUTENT	CANCER	MEDICAL	
SYLATRON	CANCER	MEDICAL	
SYLVANT	CANCER	MEDICAL	
SYNAGIS	RSV PREVENTION	MEDICAL	
SYNVISC, -ONE	ANTIARTHRITICS	MEDICAL	
TAFINLAR	CANCER	MEDICAL	
TARCEVA	CANCER	MEDICAL	
TASIGNA	CANCER	MEDICAL	
TAXOTERE	CANCER	MEDICAL	
TECFIDERA	MULTIPLE SCLEROSIS	PHARMACY TIER 2, Step Therapy Rules Apply	AVONEX, COPAXONE, REBIF, EXTAVIA, PLEGRIDY – Tier 2
TEMODAR	CANCER	MEDICAL	
TEMOZOLOMIDE	CANCER	MEDICAL	
TESTOPEL	HORMONES	MEDICAL, Limited Distribution	
THALOMID	CANCER	MEDICAL	
THERACYS	CANCER	MEDICAL	
THIOTEPA	CANCER	MEDICAL	

Medication name	Disease state/category	Coverage	Preferred alternatives
THYMOGLOBULIN	IMMUNE DEFICIENCY	MEDICAL	
THYROGEN	CANCER	MEDICAL	
TICE BCG	CANCER	MEDICAL	
TOBI	ANTIBIOTICS	PHARMACY TIER 3	
tobramycin sulfate	ANTIBIOTICS	PHARMACY TIER 1	
TOPOSAR	CANCER	MEDICAL	
TOPOTECAN HCL	CANCER	MEDICAL	
TORISEL	CANCER	MEDICAL	
TRACLEER	CARDIOVASCULAR	PHARMACY TIER 2	
TREANDA	CANCER	MEDICAL	
TRELSTAR DEPOT	CANCER	MEDICAL	
TRELSTAR LA	CANCER	MEDICAL	
TRETTEN	HEMOPHILIA	MEDICAL	
TRISENOX	CANCER	MEDICAL	
TYKERB	CANCER	MEDICAL	
TYSABRI	MISCELLANEOUS SPECIALTY	MEDICAL, Step Therapy Rules Apply	AVONEX, COPAXONE, REBIF, EXTAVIA, PLEGRIDY – Tier 2
TYVASO	CARDIOVASCULAR	MEDICAL	
VALCHLOR	CANCER	MEDICAL	
VALSTAR	CANCER	MEDICAL	
VANDETANIB	CANCER	MEDICAL	
VANTAS	CANCER	MEDICAL	
VECTIBIX	CANCER	MEDICAL	
VELCADE	CANCER	MEDICAL	
VELETRI	CARDIOVASCULAR	MEDICAL	
VENTAVIS	CARDIOVASCULAR	MEDICAL	
VICTRELIS	HEPATITIS C	MEDICAL	
VIDAZA	CANCER	MEDICAL	
VIEKIRA PAK	HEPATITIS C	PHARMACY TIER 2	
VIMIZIM	ENZYME DEFICIENCIES	PHARMACY TIER 3	
VINBLASTINE SULF	CANCER	MEDICAL	
VINCASAR PFS	CANCER	MEDICAL	
VINCRISTINE SULFATE	CANCER	MEDICAL	
VINORELBINE TART	CANCER	MEDICAL	
VISUDYNE	MISCELLANEOUS SPECIALTY	MEDICAL	
VIVITROL	MISCELLANEOUS SPECIALTY	MEDICAL	
VOTRIENT	CANCER	MEDICAL	
VPRIV	ENZYME DEFICIENCIES	MEDICAL	
VUMON	CANCER	MEDICAL	
WINRHO SDF	IMMUNE DEFICIENCY	MEDICAL	
XALKORI	CANCER	MEDICAL	
XELJANZ	ANTIARTHRITICS	PHARMACY TIER 3, Step Therapy Rules Apply	ENBREL, HUMIRA - Tier 2
XELODA	CANCER	MEDICAL	
XENAZINE	GENETIC DISORDER	MEDICAL	
XEOMIN	NEUROMUSCULAR	MEDICAL	
XGEVA	BONE CONDITIONS	MEDICAL	
XIAFLEX	MISCELLANEOUS SPECIALTY	MEDICAL	
XOLAIR	ANTIASTHMATICS	MEDICAL	
XTANDI	CANCER	MEDICAL	
XYNTHA	HEMOPHILIA	MEDICAL	
XYNTHA SOLOFUSE	HEMOPHILIA	MEDICAL	
XYREM	SEDATIVE/HYPNOTICS	PHARMACY TIER 2, Limited Distribution	
YERVOY	CANCER	MEDICAL, Limited Distribution	
ZALTRAP	CANCER	MEDICAL	
ZANOSAR	CANCER	MEDICAL	
ZAVESCA	ENZYME DEFICIENCIES	MEDICAL	
ZELBORAF	CANCER	MEDICAL	
ZEMAIRA	RESPIRATORY CONDITIONS	MEDICAL	
ZEVALIN	CANCER	MEDICAL, Limited Distribution	
ZOLADEX	CANCER	MEDICAL	
ZOLEDRONIC ACID	BONE CONDITIONS	MEDICAL	

Medication name	Disease state/category	Coverage	Preferred alternatives
ZOLINZA	CANCER	MEDICAL	
ZOMETA	BONE CONDITIONS	MEDICAL	
ZYKADIA	CANCER	MEDICAL	
ZYTIGA	CANCER	MEDICAL	

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.

Antidepressant Step Therapy

1. Pristiq/Viibryd/desvenlafaxine
   - One of the following generic medications will be required before a brand name medication is authorized. Generic medications must be prescribed for a minimum of 30 days. Documentation of attempt and failure of a generic within the last 12 months will be considered as fulfilling this requirement.
     - bupropion sr, xl
     - citalopram
     - duloxetine
     - escitalopram
     - fluvoxamine
     - fluoxetine
     - mirtazapine
     - paroxetine
     - sertraline
     - venlafaxine
   - Pristiq will be covered at the 2nd tier copay level (after step therapy for a minimum of 30 days).
   - Viibryd will be covered at the 2nd tier copay level (after step therapy for a minimum of 30 days).
   - Desvenlafaxine will be covered at the 3rd tier copay level (after step therapy for a minimum of 30 days).
2. Fetzima
   - At least a 90-day trial of venlafaxine or duloxetine, followed by a 30-day trial of Pristiq, is required. Documentation of attempt and failure of a generic, and subsequent failure of Pristiq, within the last 12 months will be considered as fulfilling this requirement.
   - Fetzima will be covered at the 2nd tier copay level (after completion of the required step-therapy).

Crestor/Liptruzet/Zetia Step Therapy

A minimum 30-day trial of one of the following generic statin medications in the last 12 months is required for possible consideration.

- atorvastatin
- fluvastatin
- lovastatin
- pravastatin
- simvastatin

Proton Pump Inhibitor (PPI) Step Therapy

- Minimum 30-day trials each of generic omeprazole, pantoprazole, and rabeprazole are required before approval of a non-formulary PPI will be considered.
- Prior authorization is required for first-omeprazole, first-lansoprazole, and lansoprazole solutabs. This is based on medical necessity for all members over the age of 12 years old.

Pharmaceutical Samples and Formulary Management

The provision of pharmaceutical samples (from the prescriber or manufacturer assistance/free trial programs) does not guarantee coverage under the provisions of the pharmacy benefit. All criteria listed in plan policies must be met in order to obtain coverage of medications. In addition, the use of pharmaceutical samples will not be considered when evaluating the Member's medical condition or prior prescription history for medications that require prior authorization.

Certification

Medications that require prospective (pre-service) review and certification. For coverage of the following formulary exceptions, a written certificate of medical necessity from your prescriber documenting the requirements listed below is required. Fax to the Pharmacy Management Team at (605) 328-6813.

Medication	Coverage requirements
Byetta	Failure of covered oral medications
Bydureon	Failure of covered oral medications
Omega-3 Ethyl Esters (generic Lovaza)	Triglyceride level must be greater than 500
Testosterone products (Androderm, Androgel, Axiron, testosterone injectable)	Require 2 below-normal testosterone levels within the last 6 months (collected 30 days apart), as well as symptoms of testosterone deficiency other than erectile dysfunction
SymlinPen	Failure of covered oral medications
Uloric	Failure of generic allopurinol
Victoza	Failure of covered oral medications

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Limited and Non-Covered Services

Excluded Medications and Supplies: the following medications are specifically **EXCLUDED** from coverage under your Plan. However, a request for coverage may be granted if a regulation requiring coverage is in place, a formulary exception is made, or a previous certification has been granted by the Plan. Requests for coverage of these medications will not be considered unless you have tried and failed a formulary alternative.

- Medications not listed in the formulary
- Replacement of a prescription medication due to loss, damage, or theft
- Outpatient medications dispensed in a provider's office or non-retail pharmacy location (unless specifically covered by policy)
- Medications that may be received without charge under a federal, state, or local program
- Medications for cosmetic purposes, including baldness, removal of facial hair, or pigmenting or anti-pigmenting of the skin
- Refills of any prescription older than one year
- Compounded medications containing no legend (prescription) medication (restrictions are in place regarding compound medications in general as noted below)
- Acne medication for Members over the age of thirty (30)
- B-12 injections (except for pernicious anemia)
- Drug Efficacy Study Implementation ("DESI") medications
- Experimental or investigational medications or medication usage if not recognized by the Food and Drug Administration or part of an approved clinical trial
- Growth hormone, except when medically indicated and prior-approved by the Plan
- Orthomolecular therapy, including nutrients, food supplements and baby formula (except to treat PKU or otherwise required to sustain life), nutritional and electrolyte substances
- Medications and associated expenses and devices not approved by the FDA for a particular use except as required by law (unless provider certifies off-label use with a letter of medical necessity)
- Medications, equipment or supplies available over-the-counter (OTC) (except for insulin and select diabetic supplies, e.g., insulin syringes, needles, test strips and lancets) that by federal or state law do not require a prescription order
- Any medication that is equivalent to an OTC medication except for medications that have a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force and only when prescribed by a healthcare practitioner
- Anorexiants or weight management medications, except per Plan policy
- Whole blood and blood components not classified as medications in the United States Pharmacopoeia
- Medications used to treat infertility
- Unit dose packaging
- Medications for treatment of sexual dysfunction, impotence, or erectile dysfunction (organic or non-organic in nature)

Medication Exclusion List

The following medications (and their generic equivalent, if listed) are excluded by your Plan, as there are similar medications in this category available for coverage. Brand name products will not be covered when a generic is available.

***indicates all preferred alternatives must be trialed before coverage will be considered for an excluded medication*

Excluded Medication	Preferred Alternatives
ACCU-CHECK TEST STRIPS	One Touch Ultra, One Touch Verio
ACIPHEX**	omeprazole, pantoprazole, rabeprazole
ACTONEL, risedronate	alendronate, ibadronate
AEROSPAN	Flovent, Pulmicort, Qvar
ALOCRIL	olopatadine, Pataday
ALOMIDE	olopatadine, Pataday
ALORA	estradiol transdermal patch
ALREX	olopatadine, Pataday
ALTOPREV	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
ALVESCO	Flovent, Pulmicort, Qvar

Excluded Medication	Preferred Alternatives
AMBIEN CR**	eszopiclone, zaleplon, zolpidem (or zolpidem CR)
ANGELIQ	norethindrone ac/eth estradiol, Prempro, Premphase
APIDRA	Novolin, Novolog
APIDRA SOLOSTAR	Novolin, Novolog
APRISO	Asacol HD, Delzicol, Lialda, Pentasa
ASMANEX	Flovent, Pulmicort, Qvar
ATELVIA	alendronate, ibadronate
ATRALIN	adapalene, clindamycin-benzoyl peroxide, Epiduo
AVITA	adapalene, clindamycin-benzoyl peroxide, Epiduo

Excluded Medication	Preferred Alternatives
AZOR	amlodipine + losartan
BECONASE AQ	azelastine nasal spray
BELSOMRA**	eszopiclone, zaleplon, zolpidem (or zolpidem CR)
BENICAR	candesartan, irbesartan, losartan, telmisartan
BENICAR HCT	irbesartan + HCTZ, losartan + HCTZ, telmisartan + HCTZ
BEPREVE	olopatadine, Pataday
BESIVANCE	Vigamox
BETASERON	Avonex, Copaxone, Rebif
BEYAZ	generic oral contraceptives, Nuvaring
BINOSTO	alendronate, ibadronate
BONIVA	alendronate, ibadronate
BREEZE 2	One Touch Ultra, One Touch Verio
BRINTELLIX	fluoxetine, paroxetine, Viibryd
BRISDELLE	fluoxetine, paroxetine, Viibryd
BROMDAY	Acuvail
BROVANA	Perforomist
CARDURA XL	alfuzosin, finasteride, tamsulosin
CENESTIN	Premarin
CIPRO HC	ofloxacin, Ciprodex
CLIMARA	Combipatch
CONTOUR STRIPS	One Touch Ultra, One Touch Verio
DEXILANT**	omeprazole, pantoprazole, rabeprazole
DIDGET	One Touch Ultra, One Touch Verio
DIPENTUM	Asacol HD, Delzicol, Lialda, Pentasa
DUEXIS	famotidine + ibuprofen
DULERA	Advair, Symbicort
DUREZOL	Lotemax
EDARBI	candesartan, irbesartan, losartan, telmisartan
EDARBYCLOR	candesartan-HCTZ, irbesartan-HCTZ, losartan-HCTZ, telmisartan-HCTZ
EDLUAR**	eszopiclone, zaleplon, zolpidem (or zolpidem CR)
EFFEXOR XR	duloxetine, venlafaxine
EMADINE	olopatadine, Pataday
ENABLEX	Toviaz , Vesicare
ENJUVIA	Premarin
EXFORGE HCT	amlodipine + losartan + HCTZ
FEMTRACE	Premarin
FIBRICOR	fenofibrate, fenofibric acid
FML FORTE	Lotemax
FORTESTA	Androderm, Androgel, Axiron
FOSAMAX + D	alendronate, ibadronate
FREESTYLE TEST STRIPS	One Touch Ultra, One Touch Verio
GELNIQUE	Toviaz, Vesicare
GENERESS FE	generic oral contraceptives, Nuvaring
GENOTROPIN	Humatrope, Nutropin
GLUMETZA	Janumet, Januvia, Kombiglyze, Onglyza
HUMALOG	Novolog, Novolin
HUMULIN (except U-500)	Novolog, Novolin
INTERMEZZO**	eszopiclone, zaleplon, zolpidem (or zolpidem CR)
JARDIANCE	Farxiga, Invokana
JENTADUETO	Janumet, Januvia, Kombiglyze, Onglyza
KADIAN	Oxycontin
KAZANO	Janumet, Januvia, Kombiglyze, Onglyza
LASTACAFT	azelastine, olopatadine, Pataday

Excluded Medication	Preferred Alternatives
LESCOL XL	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
LIPOFEN	fenofibrate, fenofibric acid
LIVALO	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
LO LOESTRIN FE	generic oral contraceptives, Nuvaring
LO MINASTRIN FE	generic oral contraceptives, Nuvaring
MAXAIR AUTOHALER	ProAir HFA, ProAir Respiclick, Ventolin HFA
MENEST	Premarin
MENOSTAR	estradiol transdermal patch
MICARDIS	candesartan, irbesartan, losartan, telmisartan
MICARDIS HCT	candesartan-HCTZ, irbesartan-HCTZ, losartan-HCTZ, telmisartan-HCTZ
MINASTRIN 24	generic oral contraceptives, Nuvaring
MINIVELLE	estradiol transdermal patch
MOXEZA	Vigamox
NATAZIA	generic oral contraceptives, Nuvaring
NESINA	Janumet, Januvia, Kombiglyze, Onglyza
NEVANAC	Acuvail
NEXIUM RX**	omeprazole, pantoprazole, rabeprazole
NIZATIDINE	cimetidine, ranitidine, famotidine
NORDITROPIN	Humatrope, Nutropin
NUCYNTA ER	Oxycontin
OMNARIS	azelastine nasal spray
OMNITROPE	Humatrope, Nutropin
OPANA ER	Oxycontin
ORACEA	doxycycline, minocycline, tetracycline
OSENI	Janumet, Januvia, Kombiglyze, Onglyza
OXYTROL	Toviaz, Vesicare
PATANASE	azelastine nasal spray
PENNSAID	Flector, Voltaren
PRECISION STRIPS	One Touch Ultra, One Touch Verio
PREVACID RX, lansoprazole**	omeprazole, pantoprazole, rabeprazole
PREVPAC	clarithromycin + amoxicillin + lansoprazole
PRILOSEC RX**	omeprazole, pantoprazole, rabeprazole
PROTONIX**	omeprazole, pantoprazole, rabeprazole
PROVENTIL HFA	ProAir HFA, ProAir Respiclick, Ventolin HFA
PROZAC	fluoxetine, paroxetine, Viibryd
QNASL	budesonide, flunisolide, Nasonex
QUARTETTE	generic oral contraceptives, Nuvaring
RAPAFLO	alfuzosin, finasteride, tamsulosin
REXULTI	aripiprazole
SAFYRAL	generic oral contraceptives, Nuvaring
SAIZEN	Humatrope, Nutropin
SANCTURA XR	Toviaz, Vesicare
SANCUSO	granisetron, ondansetron
SAPHRIS	aripiprazole, Latuda
SILENOR**	eszopiclone, zaleplon, zolpidem (or zolpidem CR)
SIMCOR	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
SOLODYN	doxycycline, minocycline, tetracycline
TESTIM	Androderm, Androgel, Axiron
TEVETEN	candesartan, irbesartan, losartan, telmisartan

Excluded Medication	Preferred Alternatives
TEVETEN HCT	candesartan-HCTZ, irbesartan-HCTZ, losartan-HCTZ, telmisartan-HCTZ
TRADJENTA	Janumet, Januvia, Kombiglyze, Onglyza
TRAVATAN Z	latanoprost, Lumigan
TREXIMET	rizatriptan, sumatriptan, Relpax
TRIBENZOR	amlodipine + losartan + HCTZ
TRIGLIDE	fenofibrate, fenofibric acid
TRULICITY	Bydureon, Byetta, Victoza
TWYNSTA	amlodipine + losartan
VASCEPA	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
VELTIN	adapalene, clindamycin-benzoyl peroxide, Epiduo
VERAMYST	azelastine nasal spray
VEXOL	Lotemax

Excluded Medication	Preferred Alternatives
VIMOVO	omeprazole + naproxen
VOGELXO	Androderm, Androgel, Axiron
VYTORIN	atorvastatin, simvastatin, Crestor, Liptruzet, Zetia
XOPENEX HFA	ProAir HFA, ProAir Respiclick, Ventolin HFA
ZETONNA	azelastine nasal spray
ZIANA	adapalene, clindamycin-benzoyl peroxide, Epiduo
ZIOPTAN	Lumigan
ZOHYDRO ER	Oxycontin
ZOLPIMIST**	eszopiclone, zaleplon, zolpidem (or zolpidem CR)

Compounded Medications

Compounded medications that contain any combination of amitriptyline, baclofen, bupivacaine, cyclobenzaprine, gabapentin, ketamine, ketoprofen, or orphenadrine are NOT COVERED due to lack of good quality scientific evidence of effectiveness or safety for these specific ingredient combinations and mode of administration.

Quantity Limit List

The following medications do not require certification, but have quantity limits/restrictions in place.

Medication	Quantity limit
almotriptan malate	Limit 6/prescription fill
Axert	Limit 6/prescription fill
butorphanol tartrate	Limit 5/prescription fill
Butrans	Limit 4/28 days
cabergoline	Limit 10/prescription fill
citalopram 40mg	Limit 30/30 days
dihydroergotamine 1mg/mL injection	Limit 10 mL/prescription fill
dihydroergotamine nasal	Limit 8 mL/23 days
doxazosin 1 mg, 2 mg, 4 mg	Limit 30/30 days
doxazosin 8 mg	Limit 60/30 days
Emend	Limit 3/prescription fill
Epipen	Limit 4 syringes/prescription fill
famciclovir	Limit 21/prescription fill
Frova	Limit 9/prescription fill
granisetron hcl	Limit 6/prescription fill
ketorolac oral tablet	Limit 20/prescription fill
lamivudine 150mg	Limit 60/30 days
leflunomide	Limit 30/30 days
naratriptan	Limit 9/prescription fill
One Touch Test Strips	Limit 200/prescription fill
paroxetine 10mg, 40mg	Limit 30/30 days
paroxetine 20mg, 30mg	Limit 60/30 days
pioglitazone	Limit 30/30 days
Relenza Diskhaler	Limit 20 doses (1 box)/prescription fill
Relpax	Limit 12/prescription fill
rizatriptan	Limit 12/prescription fill
sumatriptan tablets	Limit 12/prescription fill
sumatriptan injections	Limit 1 kit/prescription fill
sumatriptan nasal spray	Limit 6/prescription fill
Tamiflu 75mg	Limit 10 doses/prescription fill
valacyclovir	Limit 30/prescription fill
Victoza	Limit 9 mL (3 pens)/30 days
zaleplon	Limit 30/30 days
zolmitriptan	Limit 12/prescription fill
zolpidem	Limit 30/30 days

Complaints and Appeals Procedure

If you receive an adverse determination to your request for an exception to the formulary, you have the rights listed in 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.

Definitions

4-Tier Formulary - A 4-Tier medication benefit that 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 **(*the higher the tier, the higher the copay)*:

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

3-Tier Formulary - A 3-Tier medication benefit that 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 **(*the higher the tier, the higher the copay)*:

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

2-Tier Formulary - A 2-Tier medication benefit that 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 one of these tiers **(*the higher the tier, the higher the copay)*:

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

Brand Name Medication - A medication manufactured and marketed under a trademark or name by a specific manufacturer.

Certification Process - The process of obtaining prior authorization for coverage of certain prescription medications prior to dispensing, using guidelines approved by Sanford Health Plan. Refer to the section on *Medications that Require Prospective (pre-service) Review and Certification* in this booklet.

Clinic/Office/Hospital Outpatient Administered Injectable Medications - Injectable medications that may be given in a variety of settings but must be given by a healthcare professional. The majority of these medications are considered a medical benefit, with coverage applied to your deductible and coinsurance level.

Copay (also known as Copayment) - The specified charge (flat dollar amount or percentage) that you are required to pay for a prescription medication

Covered Medications - The following types of medications are covered unless subject to an exception listed in "Excluded Medications and Supplies:"

1. Federal Legend Medications: any medicinal substance which bears the legend, "Caution: federal law prohibits dispensing without a prescription," except for those medicinal substances classified as exempt narcotics pursuant to state law;
2. Some prescribed injectable medications may either be self-administered or administered by a healthcare professional. Covered injectable medications include insulin.
3. State Restricted Medications: any medicinal substance which may only be dispensed with a prescription according to state law;
4. Compound Medications: any medicinal substance that must be mixed, compounded, or otherwise prepared by a registered pharmacist and has at least one ingredient that is a federal legend or state restricted medication in a therapeutic quantity. Claims must be submitted electronically from the pharmacy for coverage consideration. Refer to the compound section on the *Medication Exclusion List* to see policy exclusions;
5. Diabetic Treatment: Items listed below are available in a 90-day supply. A supply for 30 days or less will generate 1 copay, a supply for 31-60 days will generate 2 copays and a supply for 61-90 days will generate 3 copays.
   - needles/syringes
   - injectable insulin
   - test strips (maximum 205/month with prescription order)
   - lancets
6. Contraceptive medications and devices (check your Summary of Benefits for medication coverage): includes but is not limited to oral medications, IUDs, implantable and injectable birth control devices.

Exclusion List - Sanford Health Plan reserves the right to maintain a list of medications that are specifically not covered under benefit packages per Plan policy. Payment for the medications on this list will be your responsibility in full. You may request a review of an adverse determination based on issues of medical necessity as it relates to non-covered medications, generic substitution, therapeutic interchanges and step-therapy protocols. Refer to the *Medication Exclusion List* above and the *Complaints and Appeals Procedure* in your policy (also known as Certificate of Coverage).

Formulary - A list identifying those prescription medications that are preferred by the Plan for dispensing to you, when appropriate. This list is subject to periodic review and modifications.

Generic Medication - Medications that (1) are approved by the Food and Drug Administration (FDA) as a therapeutic equivalent to the brand name equivalent, (2) contain the same active ingredient as the brand name equivalent, and (3) typically cost less than the brand name equivalent.

Maintenance Medication List - A list of medications, typically used for chronic conditions, approved by Sanford Health Plan, which are allowed to be dispensed in 90-day quantities.

Medical Benefit - Refers to medications that are covered at the deductible/coinsurance level, not a copay.

Member - An individual eligible for benefits under the Plan as determined by the Plan.

Non-Participating Pharmacy - A pharmacy that does not have a contract with Express Scripts Inc., on behalf of Sanford Health Plan. **If you utilize a non-participating pharmacy, except in an emergency, you are responsible for the full cost of the medication.**

Non-Preferred Brand-Name Medication – Brand name medication not on Sanford Health Plan's formulary. Requests for coverage of non-preferred brand name medications will not be considered unless you have tried and failed a formulary alternative. These medications are provided at a higher cost share to you (3rd or 4th Tier copay in a 3-Tier or 4-Tier Formulary, if applicable).

Oral Contraceptives - Contraceptive medications and devices will be covered for non-grandfathered health plans with no member cost sharing (no deductible, copays or coinsurance amounts).

Over-the-Counter (OTC) Medication - A medication that does not require a prescription order under Federal or State law. Sanford Health Plan does not cover any medications that can be obtained over-the-counter.

Participating Pharmacy - A pharmacy that has contracted with Express Scripts Inc. on behalf of the Plan to deliver prescription medication services to you. The participating pharmacy may be a hospital, pharmacy or other facility that has contractually accepted the terms and conditions set forth by the Plan. Refer to the participating pharmacy listing or Express Scripts website found on your secure member account at sanfordhealthplan.com/memberlogin. **If you do not utilize your prescription card, except in an emergency, you are responsible for the full cost of the prescription medication.**

Preferred Brand-Name Medication - A prescription medication that is available only as a name brand medication, is preferred by Sanford Health Plan, and is listed in the Plan Formulary. A formulary brand name medication is typically available at the 2nd tier copay in a 3- Tier or 4- Tier Formulary.

Prescription Medication Product - A medication, product, or device approved by the Food and Drug Administration (FDA) and dispensed under federal or state law only, pursuant to a prescription order or refill.

Reasonable Costs - Costs that do not exceed the lesser of: (a) a negotiated schedule of payment developed by the Plan (which is accepted as payment in full by participating practitioner and/or providers within the Plan's service area) or (b) the prevailing marketplace charges.

Self-Injectable - Self-administered injectable medications that can be given at home by you or your caregiver. Typically, these medications are covered under the pharmacy benefit.

Specialty Medications - Specialty medications are considered both injectable and non-injectable medications that have one or more of several key characteristics, including:

- Requirement for frequent dosing adjustments and/or intensive clinical monitoring
- Need for intensive patient training and compliance assistance to facilitate therapeutic goals
- Limited or exclusive product availability and distribution
- Specialized product handling and/or administration requirements
- Cost in excess of $500 for a 30-day supply

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 option may be tried, etc. This program is designed to save you money by trying alternative medications before more expensive options are used.

Supply - Medications are typically dispensed in quantities of 30-day supply or less for one copay, unless otherwise approved by the Plan. Maintenance medications may be dispensed in a 90-day supply, but a copay applies to each 30-day supply received.

Affordable Care Act (ACA) Mandated Medication Coverage

The Affordable Care Act requires all non-grandfathered health plans to cover ten categories of essential health benefits. One of these essential health benefits categories includes prescription medications. Sanford Health Plan is required to cover the following over the counter (OTC) medications when prescribed by a physician/practitioner and filled by a participating pharmacy.

Essential Health Benefits (EHB)

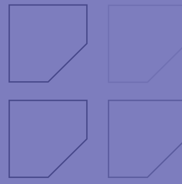
Medication category	Dosage form	Criteria
Aspirin to prevent cardiovascular disease	Generic, over-the-counter (OTC), single-entity aspirin ≤ 325 mg	Men ages 45 to 79 Women ages 55 to 79
Aspirin to prevent preeclampsia	Generic, over-the-counter, single-entity aspirin (81 mg only)	Women < 55 years of age
Fluoride	Generic prescription (RX) and generic OTC products (single entity and combination products)	6 months-5 years of age
Folic Acid	Generic RX and Generic OTC (0.4mg and 0.8mg only)	Women ≤ 50 years of age
Iron Supplements	Generic RX and generic OTC (single entity and combo products)	Children older than 6 months of age through 12 months
Vitamin D	Generic RX and generic OTC (single entity with calcium and ≤1,000 units of Vitamin D)	Age ≥ 65 years
Bowel Preparation Agents	Generic RX only with primary indication of colonoscopy preparation	Adults; ages 50 to 75 years (2 prescriptions per 365 days)
Tobacco Cessation	FDA-approved tobacco cessation medication; ninety (90) day supply	Adults; ages 18 to 79 (2 attempts per 365 days)
Tamoxifen, Raloxifene, Soltamox	All FDA approved forms	Female breast cancer prevention

Contraceptives

The ACA mandates that FDA-approved contraceptive methods be covered by health plans for women as prescribed by practitioners. Sanford Health Plan has a formulary listing for the covered generic contraceptive oral medications, as well as the brand medication NuvaRing. Diaphragms and cervical caps are also covered with a prescription.

Formulary

SANFORD HEALTH PLAN



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Formulary

for large group and grandfathered small group members and Sanford employees

The following is a list of the most commonly prescribed medications covered under your pharmacy benefit. It represents an abbreviated version of the medication formulary for your pharmacy benefit coverage. Allowing substitution of generic products is encouraged when appropriate.

The lowest co-payment is applied to all covered generic drugs (tier 1). Generic drugs are listed in lower case and italicized. Tier 2 co-payment will apply to all preferred brand name drugs listed on this formulary. Tier 3 co-payment will apply to all non-preferred brand name drugs listed on this formulary. Brand name drugs are listed in CAPITAL letters. Consult your Summary of Benefits and Coverage (SBC) document for details on your co-payments or cost-share for these various tiers.

Important: This is NOT a complete listing of covered drugs. For a complete list of medications, access your secure member account at sanfordhealthplan.com/member login and link to the Express Scripts website. If you have questions regarding coverage contact our Pharmacy Management Team at (855) 305-5062; TTY/TDD (877) 652-1844.

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Abbreviations

- **Tier 1 -** Generic Copay
- **Tier 2 -** Preferred Brand Name Copay
- **Tier 3 -** Non-Preferred Brand Name Copay
- **PA: Prior Authorization -** The Plan requires you or your physician to get prior authorization for certain medications. This means that you will need to get approval before you fill your prescriptions. If you don't get approval, the medication may not be covered under your pharmacy benefit
- **QL: Quantity Limit -** The Plan may limit the amount of certain covered medications
- **ST: Step Therapy - P**rogram using protocols that specify the order in which different drugs for a given condition are prescribed. If a Member does not obtain the desired clinical effect or experiences side effects at one step, then the drug choice at another step may be tried. Step therapy requires the use of first-line alternatives before more expensive second-line drugs are covered by the pharmacy benefit.

IMPORTANT: Check your Summary of Benefits and Coverage (SBC) document for your copay cost

Please Note: For grandfathered plans, please consult your Certificate of Coverage for coverage benefits, as not all medications listed are a covered benefit

Drug Name	Tier	Requirements/ Limitations
ANTI - INFECTIVES		
Antifungal Agents		
clotrimazole mucous membrane	1	
fluconazole	1	
flucytosine	1	
griseofulvin microsize	1	
griseofulvin ultramicrosize	1	
itraconazole	1	QL
ketoconazole oral	1	
NOXAFIL ORAL	3	
nystatin oral	1	
SPORANOX ORAL SOLUTION	3	
terbinafine hcl oral	1	
voriconazole oral	1	
Antivirals		
abacavir	1	
abacavir-lamivudine-zidovudine	1	
acyclovir oral capsule	1	
acyclovir oral suspension 200 mg/5 ml	1	
acyclovir oral tablet	1	
adefovir	1	
amantadine hcl	1	
APTIVUS	3	
ATRIPLA	2	
BARACLUDE	3	
COMPLERA	3	
CRIXIVAN ORAL CAPSULE	2	
DESCOVY	3	
didanosine	1	
EDURANT	3	
EMTRIVA	2	
entecavir	1	
EPIVIR HBV	2	
EPZICOM	2	
EVOTAZ	3	
famciclovir	1	QL
GENVOYA	3	
INTELENCE	3	
INVIRASE	2	
ISENTRESS ORAL POWDER IN PACKET	3	
ISENTRESS ORAL TABLET	2	
ISENTRESS ORAL TABLET,CHEWABLE	2	

Drug Name	Tier	Requirements/ Limitations
KALETRA	2	
lamivudine oral solution	1	
lamivudine oral tablet 100 mg, 300 mg	1	
lamivudine oral tablet 150 mg	1	QL
lamivudine-zidovudine	1	
LEXIVA	2	
nevirapine	1	
NORVIR	2	
ODEFSEY	3	
oseltamivir oral capsule 30 mg, 45 mg	1	
oseltamivir oral capsule 75 mg	1	QL
PREZCOBIX	3	
PREZISTA	2	
RELENZA DISKHALER	2	QL
RESCRIPTOR	2	
RETROVIR ORAL CAPSULE	3	
REYATAZ ORAL CAPSULE 150 MG, 200 MG, 300 MG	2	
REYATAZ ORAL POWDER IN PACKET	3	
rimantadine	1	
SELZENTRY	3	
stavudine	1	
STRIBILD	3	
SUSTIVA	2	
TAMIFLU ORAL SUSPENSION	2	QL
TIVICAY	3	
TRIUMEQ	3	
TRUVADA	2	
TYBOST	3	
TYZEKA	3	
valacyclovir	1	QL
VALCYTE	2	
valganciclovir	1	
VIDEX 2 GRAM PEDIATRIC	2	
VIRACEPT ORAL TABLET	2	
VIRAMUNE	2	
VIRAMUNE XR	3	
VIREAD ORAL POWDER	3	
VIREAD ORAL TABLET	2	
VITEKTA	3	
ZIAGEN	2	
zidovudine	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
Cephalosporins		
cefaclor oral capsule	1	
cefaclor oral suspension	1	
cefaclor oral tablet extended release 12 hr	1	
cefadroxil oral capsule	1	
cefadroxil oral suspension	1	
cefadroxil oral tablet	1	
cefdinir	1	
cefditoren pivoxil	1	
cefixime	1	
cefpodoxime	1	
cefprozil	1	
ceftibuten	1	
CEFTIN ORAL SUSPENSION	2	
cefuroxime axetil oral tablet	1	
cephalexin	1	
SUPRAX ORAL CAPSULE	3	
SUPRAX ORAL TABLET,CHEWABLE	3	
Erythromycins and Other Macrolides		
azithromycin oral	1	
clarithromycin	1	
DIFICID	3	
e.e.s. 400 oral tablet	1	
E.E.S. GRANULES	2	
ERYPED 200	2	
ERYPED 400	2	
ery-tab oral tablet, delayed release (dr/ ec) 250 mg, 333 mg	1	
ERY-TAB TABLET, DELAYED REL 500 MG	2	
erythrocin (as stearate) tablet 250 mg	1	
erythromycin ethylsuccinate oral tablet	1	
erythromycin oral capsule, delayed release(dr/ec)	1	
erythromycin oral tablet	1	
ZMAX	2	
Miscellaneous Anti-infectives		
ALBENZA	2	
ALINIA	2	
atovaquone	1	
atovaquone-proguanil	1	
BILTRICIDE	3	
chloroquine phosphate oral	1	
clindamycin hcl	1	
clindamycin palmitate hcl	1	
clindamycin pediatric	1	
COARTEM	3	
CYCLOSERINE	2	
dapsone	1	
EMVERM	3	
ethambutol	1	
hydroxychloroquine oral	1	
IMPAVIDO	3	
isoniazid oral	1	
ivermectin oral	1	
KETEK	2	
linezolid	1	PA
mefloquine	1	
MEPRON	2	
metronidazole oral	1	
MYCOBUTIN	2	QL
NEBUPENT	2	QL
neomycin	1	
paromomycin	1	
PASER	2	
PRIFTIN	2	
PRIMAQUINE	2	
pyrazinamide	1	
quinine sulfate	1	
rifabutin	1	QL
RIFAMATE	2	
rifampin oral	1	
RIFATER	2	
SIRTURO	3	
SIVEXTRO ORAL	3	
STROMECTOL	2	
tinidazole	1	
TRECATOR	2	
XIFAXAN	3	PA

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
Penicillins		
amoxicillin oral capsule	1	
amoxicillin oral suspension	1	
amoxicillin oral tablet	1	
amoxicillin tablet, chewable 125 mg, 250 mg	1	
amoxicillin-pot clavulanate	1	
ampicillin	1	
AUGMENTIN ORAL SUSPENSION FOR RECONSTITUTION 125-31.25 MG/5 ML	2	
dicloxacillin	1	
penicillin v potassium	1	
Quinolones		
AVELOX	2	
AVELOX ABC PACK	2	
ciprofloxacin	1	
ciprofloxacin (mixture)	1	
ciprofloxacin hcl oral	1	
levofloxacin oral	1	
moxifloxacin	1	
ofloxacin oral tablet 400 mg	1	
Sulfas and Related Agents		
sulfadiazine oral	1	
sulfamethoxazole-trimethoprim oral	1	
sulfatrim	1	
Tetracyclines		
avidoxy	1	
demeclocycline	1	
doxycycline hyclate oral capsule	1	
doxycycline hyclate tablet 100 mg, 20 mg	1	
doxycycline hyclate tablet, delayed release	1	
doxycycline monohydrate oral capsule	1	
doxycycline monohydrate oral suspension	1	
doxycycline monohydrate oral tablet	1	
minocycline oral capsule	1	
minocycline oral tablet	1	
mondoxyne nl	1	
morgidox oral capsule 100 mg	1	
tetracycline	1	

Drug Name	Tier	Requirements/ Limitations
Urinary Tract Agents		
methenamine hippurate	1	
methenamine mandelate	1	
MONUROL	2	
nitrofurantoin macrocrystal	1	
nitrofurantoin monohyd/m-crystal	1	
nitrofurantoin oral	1	
PRIMSOL	2	
trimethoprim	1	
Vancomycin		
vancomycin oral capsule	1	
ANTINEOPLASTIC & IMMUNOSUPPRESSANT DRUGS		
Adjunctive Agents		
leucovorin calcium oral	1	
MESNEX ORAL	2	
Antineoplastic & Immunosuppressant Drugs		
ASTAGRAF XL	3	
azathioprine	1	
CELLCEPT ORAL SUSPENSION	2	
cyclosporine modified	1	
cyclosporine oral capsule	1	
DROXIA	2	
EMCYT	2	
ENVARSUS XR	3	
gengraf	1	
hydroxyurea	1	
megestrol oral suspension 400 mg/10 ml (40 mg/ml), 625 mg/5 ml	1	
megestrol oral tablet	1	
mercaptopurine	1	
methotrexate sodium	1	
methotrexate sodium (pf)	1	
mycophenolate mofetil	1	
mycophenolate sodium	1	
MYLERAN	2	
RAPAMUNE	2	
SANDIMMUNE ORAL	2	
sirolimus	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
SOLTAMOX	3	
TABLOID	2	
tacrolimus oral	1	
tamoxifen	1	
TRELSTAR INTRAMUSCULAR SUSPEN-SION FOR RECONSTITUTION 11.25 MG, 3.75 MG	3	
TREXALL	2	
AUTONOMIC & CNS DRUGS, NEUROLOGY & PSYCHOLOGY		
Anticonvulsants		
APTIOM	3	
BANZEL	3	
BRIVIACT ORAL	3	
carbamazepine capsule, er multiphase 12 hr	1	
carbamazepine suspension 100 mg/5 ml	1	
carbamazepine oral tablet	1	
carbamazepine oral tablet ext- release 12 hr	1	
carbamazepine oral tablet, chewable	1	
CELONTIN ORAL CAPSULE 300 MG	2	
clonazepam	1	
DEPAKENE	2	
DIASTAT	2	
DIASTAT ACUDIAL	2	
diazepam rectal	1	
divalproex	1	
epitol	1	
EQUETRO	3	
ethosuximide	1	
felbamate	1	
FELBATOL	2	
FYCOMPA ORAL SUSPENSION	3	
FYCOMPA ORAL TABLET	3	
gabapentin oral capsule	1	
gabapentin oral solution 250 mg/5 ml	1	
gabapentin oral tablet 600 mg, 800 mg	1	
GABITRIL	2	
GRALISE	3	
GRALISE 30-DAY STARTER PACK	3	
LAMICTAL XR	2	
LAMICTAL XR STARTER (BLUE)	2	
LAMICTAL XR STARTER (GREEN)	2	
LAMICTAL XR STARTER (ORANGE)	2	
lamotrigine oral tablet	1	
lamotrigine tablet disintegrating, dose pk	1	
lamotrigine oral tablet ext-release 24hr	1	
lamotrigine oral tablet, chewable dispersible	1	
lamotrigine oral tablet, disintegrating	1	
levetiracetam oral	1	
LYRICA	2	QL
ONFI ORAL SUSPENSION	3	
ONFI ORAL TABLET 10 MG, 20 MG	3	
oxcarbazepine	1	
PEGANONE	2	
phenobarbital	1	
PHENYTEK	2	
phenytoin oral suspension 125 mg/5 ml	1	
phenytoin oral tablet, chewable	1	
phenytoin sodium extended	1	
POTIGA	3	
primidone	1	
roweepra	1	
tiagabine	1	
topiramate oral capsule, sprinkle	1	
TOPIRAMATE ORAL CAPSULE, SPRINKLE, ER 24HR	3	
topiramate oral tablet	1	
TRILEPTAL	2	
TROKENDI XR	3	
valproic acid	1	
valproic acid (as sodium salt) oral solution 250 mg/5 ml	1	
VIMPAT ORAL SOLUTION	2	
VIMPAT ORAL TABLET	2	
zonisamide	1	
Antiparkinsonism Agents		
AZILECT	2	
benztropine oral	1	
bromocriptine	1	
carbidopa	1	
carbidopa-levodopa	1	
carbidopa-levodopa-entacapone	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
entacapone	1	
NEUPRO	3	
pramipexole	1	
ropinirole	1	
selegiline hcl	1	
TASMAR ORAL TABLET 100 MG	2	
tolcapone	1	
trihexyphenidyl	1	
ZELAPAR	3	
Migraine & Cluster Headache Therapy		
almotriptan malate	1	QL
D.H.E.45	2	QL
dihydroergotamine injection	1	QL
dihydroergotamine nasal	1	QL
ERGOMAR	2	
frovatriptan	1	QL
isometh-dichloral-acetaminophen	1	
isomethepten-caf-acetaminophen oral tablet 65-20-325 mg	1	
migergot	1	
migragesic ida	1	
naratriptan	1	QL
nodolor	1	
rizatriptan	1	QL
sumatriptan	1	QL
sumatriptan succinate oral	1	QL
sumatriptan succinate subcutaneous cartridge	1	QL
sumatriptan succinate subcutaneous pen injector	1	QL
sumatriptan succinate subcutaneous solution	1	QL
sumatriptan succinate subcutaneous syringe 6 mg/0.5 ml	1	QL
zolmitriptan	1	QL
Miscellaneous Neurological Therapy		
donepezil	1	
galantamine	1	
HORIZANT	3	
memantine oral solution	1	
memantine oral tablet	1	
MEMANTINE ORAL TABLETS, DOSE PACK	3	
NAMENDA XR	3	

Drug Name	Tier	Requirements/ Limitations
NAMZARIC ORAL CAPSULE, SPRINKLE, ER 24HR	3	
NUEDEXTA	3	
rivastigmine	1	
rivastigmine tartrate	1	
Muscle Relaxants & Antispasmodic Therapy		
baclofen	1	
carisoprodol	1	
carisoprodol-aspirin-codeine	1	
carisoprodol-aspirin	1	
chlorzoxazone	1	
cyclobenzaprine oral tablet	1	
dantrolene	1	
meprobamate	1	
metaxall	1	
metaxalone	1	
methocarbamol oral	1	
orphenadrine citrate oral	1	
pyridostigmine bromide	1	
tizanidine	1	
Narcotic Analgesics		
ABSTRAL	3	
acetaminophen-caff-dihydrocod capsule	1	
acetaminophen-codeine oral solution 120-12 mg/5 ml	1	
acetaminophen-codeine oral tablet	1	
ascomp with codeine	1	
aspirin-caffeine-dihydrocodeine	1	
BELBUCA	3	
buprenorphine hcl sublingual	1	
butalbital compound w/codeine	1	
butalbital-acetaminop-caf-cod	1	
butalbital-acetaminophen	1	
butalbital-acetaminophen-caff oral capsule	1	
butalbital-acetaminophen-caff oral tablet 50-325-40 mg	1	
butalbital-aspirin-caffeine oral capsule	1	
BUTRANS	3	QL
capacet	1	
codeine sulfate oral tablet	1	
codeine-butalbital-aspirin -caffeine	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
diskets	1	
endocet oral tablet 10-325 mg, 2.5-325 mg, 5-325 mg, 7.5-325 mg	1	
fentanyl citrate	1	
fentanyl transdermal patch 72ur 12mcg/hr, 25mcg/hr, 50mcg/hr, 75mcg/h, 100mcg/h	1	
FENTANYL TRANSDERMAL PATCH 72 HOUR 37.5MCG/HR, 62.5MCG/HR, 87.5MCG/HR	3	
FENTORA	3	
hydrocodone-acetaminophen oral solution 7.5-325 mg/15 ml	1	
hydrocodone-acetaminophen oral tablet 2.5-325mg, 5-300 mg, 5-325mg, 7.5-300mg, 7.5-325mg, 10-300mg, 10-325mg	1	
hydrocodone-ibuprofen	1	
hydromorphone oral	1	
hydromorphone rectal	1	
HYSINGLA ER	3	
ibuprofen-oxycodone	1	
IONSYS	3	
levorphanol tartrate	1	
lorcet (hydrocodone)	1	
lorcet hd	1	
lorcet plus oral tablet 7.5-325 mg	1	
lortab 10-325	1	
lortab 5-325	1	
lortab 7.5-325	1	
marten-tab	1	
meperidine oral	1	
methadone oral concentrate	1	
methadone oral solution	1	
methadone oral tablet	1	
methadone oral tablet, soluble	1	
methadose oral concentrate	1	
methadose oral tablet, soluble	1	
morphine concentrate oral solution	1	
morphine oral	1	
morphine rectal	1	
oxycodone oral capsule	1	
oxycodone oral concentrate	1	
oxycodone oral solution	1	
oxycodone oral tablet	1	

Drug Name	Tier	Requirements/ Limitations
oxycodone-acetaminophen oral solution	1	
oxycodone-acetaminophen oral tablet 2.5-325 mg, 5-325 mg, 7.5-325 mg, 10-325 mg	1	
oxycodone-aspirin	1	
OXYCONTIN ORAL TABLET	2	
oxymorphone	1	
PERCOCET ORAL TABLET 2.5-325MG, 5-325MG, 7.5-325MG, 10-325 MG	3	
PRIMLEV	3	
reprexain	1	
ROXICODONE	3	
SUBSYS	3	
tencon	1	
verdrocet	1	
vicodin	1	
vicodin es	1	
vicodin hp	1	
XODOL 10/300	3	
XODOL 5/300	3	
XODOL 7.5/300	3	
xylon 10	1	
zamicet	1	
zebutal oral capsule 50-325-40 mg	1	
Non-Narcotic Analgesics		
BUNAVAIL	3	
buprenorphine-naloxone	1	
butorphanol tartrate nasal	1	QL
celecoxib	1	
choline, magnesium salicylate	1	
diclofenac potassium	1	
diclofenac sodium oral	1	
diclofenac sodium topical drops	1	QL
diclofenac sodium topical gel 1 %	1	QL
diclofenac-misoprostol	1	
diflunisal	1	
etodolac	1	
FENOPROFEN ORAL CAPSULE	3	
fenoprofen oral tablet	1	
FLECTOR	3	
flurbiprofen	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
ibuprofen tablet 400 mg, 600 mg, 800 mg	1	
indomethacin oral	1	
ketoprofen oral capsule	1	
ketoprofen oral capsule, extended release pellets 24 hour 200 mg	1	
ketorolac oral	1	QL
klofensaid ii	1	
meclofenamate oral	1	
mefenamic acid	1	
meloxicam	1	
nabumetone	1	
NALFON ORAL CAPSULE 400 MG	3	
naltrexone	1	
naproxen	1	
naproxen sodium tablet 275 mg, 550 mg	1	
naproxen sodium tablet, er multiphase 24 hr	1	
NARCAN	3	
NUCYNTA	3	
oxaprozin	1	
pentazocine-naloxone	1	
piroxicam	1	
REVIA	2	
salsalate	1	
SUBOXONE	3	
sulindac oral	1	
tolmetin	1	
tramadol oral tablet	1	
tramadol oral tablet ext-release 24 hr	1	
tramadol oral tablet, er multiphase 24 hr	1	
tramadol-acetaminophen	1	
VOLTAREN TOPICAL	2	
ZUBSOLV SUBLINGUAL TABLET 1.4-0.36 MG, 5.7-1.4 MG	3	
Psychotherapeutic Drugs		
ADZENYS XR-ODT	3	
alprazolam	1	
alprazolam intensol	1	
amitriptyline	1	
amitriptyline-chlordiazepoxide	1	
amoxapine	1	
aripiprazole	1	

Drug Name	Tier	Requirements/ Limitations
armodafinil	1	
bupropion hcl	1	
buspirone	1	
chlordiazepoxide hcl	1	
chlorpromazine oral	1	
citalopram oral solution	1	
citalopram oral tablet 10 mg, 20 mg	1	
citalopram oral tablet 40 mg	1	QL
clomipramine	1	
clonidine hcl tablet ext-release 12 hr	1	
clorazepate dipotassium	1	
clozapine oral tablet	1	
clozapine oral tablet, disintegrating 12.5 mg, 25 mg, 100 mg	1	
CLOZAPINE TABLET, DISINTEGRATING 150 MG, 200 MG	3	
CLOZARIL	3	
DAYTRANA	3	
desipramine oral	1	
DESVENLAFAXINE	3	ST
DESVENLAFAXINE FUMARATE	3	
dexedrine	1	
DEXEDRINE SPANSULE ORAL CAPSULE, EXT-RELEASE 15 MG	3	
dexmethylphenidate capsule, er biphasic	1	
dexmethylphenidate oral tablet	1	
dextroamphetamine	1	
dextroamphetamine-amphetamine	1	
diazepam intensol	1	
diazepam oral soln 5 mg/5 ml (1 mg/ml)	1	
diazepam oral tablet	1	
doxepin oral	1	
duloxetine	1	
DYANAVEL XR	3	
ergoloid	1	
escitalopram oxalate	1	
estazolam	1	
eszopiclone	1	
fluoxetine oral capsule	1	
fluoxetine oral capsule, delayed release(dr/ec)	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
fluoxetine oral solution	1	
fluoxetine oral tablet 10 mg, 20 mg	1	
fluphenazine hcl oral	1	
flurazepam	1	
fluvoxamine capsule, ext-release 24hr	1	
fluvoxamine oral tablet 50 mg, 100 mg	1	QL
fluvoxamine oral tablet 25 mg	1	
guanfacine oral tablet ext-release 24 hr	1	
guanidine	1	
haloperidol	1	
haloperidol lactate oral	1	
imipramine hcl	1	
imipramine pamoate	1	
LATUDA	2	
lithium carbonate	1	
lithium citrate oral solution 8 meq/5 ml	1	
lorazepam intensol	1	
lorazepam oral	1	
loxapine succinate	1	
maprotiline	1	
metadate er	1	
methamphetamine	1	
METHYLIN ORAL SOLUTION	2	
METHYLIN ORAL TABLET,CHEWABLE	2	
methylphenidate oral	1	
mirtazapine	1	
modafinil	1	
molindone	1	
nefazodone	1	
nortriptyline	1	
olanzapine oral	1	
olanzapine-fluoxetine	1	
ORAP	2	
oxazepam	1	
paliperidone	1	
paroxetine hcl oral tablet	1	QL
paroxetine hcl tablet ext-release 24 hr	1	
perphenazine	1	
perphenazine-amitriptyline	1	
phenelzine	1	
pimozide	1	

Drug Name	Tier	Requirements/ Limitations
PRISTIQ	2	ST
procentra	1	
protriptyline	1	
quazepam	1	
quetiapine oral tablet	1	
QUILLICHEW ER	3	
QUILLIVANT XR	3	
risperidone oral solution	1	
risperidone oral tablet	1	
risperidone oral tablet, disintegrating	1	
seconal sodium	1	
SEROQUEL XR ORAL TABLET 24 HR	2	
sertraline	1	
STRATTERA	2	
temazepam	1	
thioridazine	1	
thiothixene	1	
tranylcypromine	1	
trazodone	1	
triazolam	1	
trifluoperazine	1	
trimipramine	1	
venlafaxine	1	
VERSACLOZ	3	
VIIBRYD ORAL TABLET	2	ST
VYVANSE	2	
zaleplon	1	QL
zenzedi oral tablet 10 mg, 5 mg	1	
ZENZEDI ORAL TABLET 2.5 MG, 7.5 MG, 15 MG, 20 MG, 30 MG	3	
ziprasidone hcl	1	
zolpidem oral tablet	1	QL
zolpidem oral tablet, ext rel multiphase	1	
CARDIOVASCULAR, HYPERTENSION & LIPIDS		
Antiarrhythmic Agents		
amiodarone oral	1	
disopyramide phosphate oral capsule	1	
dofetilide	1	
flecainide	1	

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Drug Name	Tier	Requirements/ Limitations
mexiletine	1	
MULTAQ	2	
NORPACE	2	
NORPACE CR	2	
pacerone tablet 100 mg, 200 mg, 400 mg	1	
propafenone	1	
quinidine gluconate oral	1	
quinidine sulfate	1	
sotalol af	1	
sotalol oral	1	
SOTYLIZE	3	
TIKOSYN	2	
Antihypertensive Therapy		
acebutolol	1	
afeditab cr	1	
amiloride	1	
amiloride-hydrochlorothiazide	1	
amlodipine	1	
amlodipine-benazepril	1	
amlodipine-valsartan	1	
amlodipine-valsartan-hydrochlorothiazide	1	
atenolol	1	
atenolol-chlorthalidone	1	
benazepril	1	
benazepril-hydrochlorothiazide	1	
betaxolol oral	1	
BIDIL	3	
bisoprolol fumarate	1	
bisoprolol-hydrochlorothiazide	1	
bumetanide oral	1	
BYSTOLIC	3	
BYVALSON	3	
candesartan	1	
candesartan-hydrochlorothiazide	1	
captopril	1	
captopril-hydrochlorothiazide	1	
carvedilol	1	
chlorothiazide	1	
chlorthalidone oral tablet 25 mg, 50 mg	1	
clonidine	1	

Drug Name	Tier	Requirements/ Limitations
clonidine hcl oral tablet	1	
clorpres oral tablet 0.1-15 mg, 0.2-15 mg	1	
CLORPRES ORAL TABLET 0.3-15 MG	2	
DEMSER	3	
DIBENZYLINE	2	
diltiazem hcl oral capsule, extended release 24hr 120 mg	1	
DIURIL	2	
doxazosin	1	QL
DYRENIUM	3	
enalapril maleate	1	
enalapril-hydrochlorothiazide	1	
EPANED ORAL SOLUTION	3	
eplerenone	1	
eprosartan	1	
ethacrynic acid	1	
felodipine	1	
fosinopril	1	
fosinopril-hydrochlorothiazide	1	
furosemide oral solution 10 mg/ml, 40 mg/5 ml (8 mg/ml)	1	
furosemide oral tablet	1	
guanfacine oral tablet	1	
HEMANGEOL	3	
hydralazine oral	1	
hydrochlorothiazide	1	
indapamide	1	
irbesartan	1	
irbesartan-hydrochlorothiazide	1	
isradipine	1	
labetalol oral	1	
lisinopril	1	
lisinopril-hydrochlorothiazide	1	
losartan	1	
losartan-hydrochlorothiazide	1	
methyclothiazide	1	
methyldopa	1	
methyldopa-hydrochlorothiazide	1	
metolazone	1	
metoprolol succinate	1	
metoprolol tartrate-hydrochlorothiazide	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
metoprolol tartrate oral	1	
minoxidil oral	1	
moexipril	1	
moexipril-hydrochlorothiazide	1	
nadolol	1	
nadolol-bendroflumethiazide	1	
nicardipine oral	1	
nifedical xl	1	
nifedipine	1	
nimodipine	1	
nisoldipine	1	
perindopril erbumine	1	
phenoxybenzamine	1	
pindolol	1	
prazosin oral	1	
PRESTALIA	3	
propranolol oral	1	
propranolol-hydrochlorothiazide	1	
quinapril	1	
quinapril-hydrochlorothiazide	1	
ramipril	1	
reserpine	1	
spironolactone	1	
spironolactone-hydrochlorothiazide	1	
TEKTURNA	3	
TEKTURNA HCT	3	
telmisartan	1	
telmisartan-amlodipine	1	
telmisartan-hydrochlorothiazide	1	
terazosin	1	QL
timolol maleate oral	1	
torsemide oral	1	
trandolapril	1	
trandolapril-verapamil	1	
triamterene-hydrochlorothiazide	1	
TRIBENZOR	3	
valsartan	1	
valsartan-hydrochlorothiazide	1	
verapamil oral	1	

Drug Name	Tier	Requirements/ Limitations
Cardiac Glycosides		
digitek	1	
digox	1	
digoxin oral solution 50 mcg/ml	1	
digoxin oral tablet	1	
LANOXIN TABLET 125 MCG, 250 MCG	2	
LANOXIN TABLET 187.5MCG, 62.5MCG	3	
Coagulation Therapy		
AMICAR	2	
aspirin-dipyridamole	1	
BRILINTA	2	
cilostazol	1	
clopidogrel	1	
dipyridamole oral	1	
EFFIENT	2	
ELIQUIS	3	
enoxaparin	1	
fondaparinux	1	
FRAGMIN SUBCUTANEOUS SOLUTION	2	
FRAGMIN SUBCUTANEOUS SYRINGE	2	
hep flush-10 (pf)	1	
heparin (porcine) injection cartridge	1	
heparin (porcine) injection solution	1	
heparin flush(porcine)-0.9nacl	1	
heparin lock flush (porcine) intravenous solution 100 unit/ml	1	
heparin lock flush (porcine) intravenous syringe	1	
heparin lock flush intravenous solution	1	
heparin lockflush(porcine)(pf) intravenous syringe 10 unit/ml	1	
heparin, porcine (pf) injection	1	
heparin, porcine (pf) intravenous syringe 1 unit/ml	1	
jantoven	1	
MEPHYTON	2	
monoject prefill (pf)	1	
pentoxifylline	1	
PRADAXA CAPSULE 75 MG, 150 MG	2	
ticlopidine	1	
warfarin	1	
XARELTO	2	
ZONTIVITY	2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
Lipid/Cholesterol Lowering Agents		
amlodipine-atorvastatin	1	
atorvastatin	1	
cholestyramine (with sugar)	1	
cholestyramine light	1	
colestipol	1	
fenofibrate micronized	1	
fenofibrate nanocrystallized	1	
fenofibrate oral tablet	1	
fenofibric acid	1	
fenofibric acid (choline)	1	
fluvastatin oral capsule	1	
gemfibrozil oral	1	
lovastatin	1	
niacin oral tablet extended release 24 hr	1	
NIASPAN EXTENDED-RELEASE	3	
omega-3 acid ethyl esters	1	
pravastatin	1	
prevalite	1	
rosuvastatin oral tablet 10 mg, 20 mg	1	QL
rosuvastatin oral tablet 40 mg, 5 mg	1	
simvastatin	1	
WELCHOL	3	
Miscellaneous Cardiovascular Agents		
CORLANOR	3	
ENTRESTO	3	
RANEXA	2	
VECAMYL	3	
Nitrates		
DILATRATE-SR	2	
GONITRO	3	
isosorbide dinitrate oral	1	
isosorbide mononitrate	1	
nitro-bid	1	
nitroglycerin oral	1	
nitroglycerin sublingual	1	
nitroglycerin transdermal patch 24 hour	1	
nitroglycerin translingual	1	
NITROLINGUAL	3	
NITROMIST	3	
NITROSTAT	2	

Drug Name	Tier	Requirements/ Limitations
DERMATOLOGICALS/TOPICAL THERAPY		
Antipsoriatic / Antiseborrheic		
acitretin	1	
calcipotriene	1	
calcipotriene-betamethasone	1	QL
calcitrene	1	
calcitriol topical	1	
drithocreme hp	1	
ENSTILAR	3	
EPIFOAM	2	
PRAMOSONE	2	
PRAMOSONE E	3	
PROMISEB COMPLETE	3	
seb-prev	1	
selenium sulfide topical lotion	1	
selenium sulfide topical shampoo 2.25 %	1	
SORILUX	3	
sulfacetamide sodium topical	1	
TACLONEX TOPICAL SUSPENSION	3	QL
ZITHRANOL	3	
ZITHRANOL-RR	3	
Burn Therapy		
silver sulfadiazine	1	
ssd	1	
thermazene	1	
Keratolytics		
PODOCON	3	
POTASSIUM HYDROXIDE	3	
salacyn	1	
salicylic acid er-ceramides	1	
salicylic acid topical cream	1	
salicylic acid topical cream, ext-release	1	
salicylic acid topical film forming liquid	1	
salicylic acid topical film-forming soln er	1	
salicylic acid topical foam	1	
salicylic acid topical gel	1	
salicylic acid topical liquid 26 %	1	
salicylic acid topical lotion	1	
salicylic acid topical lotion, ext- release	1	
salicylic acid topical shampoo	1	
salvax	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
Miscellaneous Dermatologicals		
avo cream	1	
bp-50% urea	1	
captracin	1	
CARAC	2	
carb-o-philic topical cream 40 %	1	
celacyn	1	
cem-urea	1	
CONDYLOX TOPICAL GEL	3	
diclofenac sodium topical gel 3 %	1	QL
doxepin topical	1	
eletone	1	
ELIDEL	2	
emulsion sb	1	
FLUOROPLEX	2	
FLUOROURACIL TOPICAL CREAM 0.5%	3	
fluorouracil topical cream 5 %	1	
fluorouracil topical solution	1	
hpr	1	
hpr plus	1	
hpr plus hydrogel	1	
lactic acid	1	
lactic acid e	1	
latrix	1	
mb hydrogel	1	
mb hydrogel (cyclomethicone)	1	
nivatopic plus	1	
PICATO	3	
podofilox	1	
PROTOPIC	2	
pruclair	1	
prudoxin	1	
prumyx	1	
prutect	1	
rea lo 39	1	
rea lo 40	1	
REGRANEX	2	QL
remeven	1	
silver nitrate applicators	1	
silver nitrate topical solution 10 %	1	
sonafine	1	

Drug Name	Tier	Requirements/ Limitations
sp antipruritic	1	
sp scar management	1	
tacrolimus topical	1	
umecta topical foam	1	
urea nail stick	1	
urea topical cream 39 %, 40 %, 45 %, 47 %, 50 %	1	
urea topical foam	1	
urea topical gel	1	
urea topical lotion 40 %, 45 %	1	
urea topical nail film suspension	1	
urea-hyaluronate sodium	1	
ure-k	1	
ZONALON	2	
Therapy for Acne		
ACANYA TOPICAL GEL WITH PUMP	3	
ACZONE	3	
AVAR LS	3	
avar topical cleanser	1	
AVAR TOPICAL FOAM	3	
AVAR TOPICAL PADS, MEDICATED	3	
AVAR-E GREEN	3	
AVAR-E LS	3	
avita topical cream	1	
AZELEX	3	
benzepro topical towelette	1	
benzoyl peroxide topical foam 9.8 %	1	
bp 10-1	1	
bpo	1	
claravis	1	
cleansing wash topical cleanser	1	
clindacin p	1	
clindamycin phosphate topical	1	
clindamycin-benzoyl peroxide	1	
EPIDUO	2	
EPIDUO FORTE	2	
ery pads	1	
erygel	1	
erythromycin with ethanol	1	
erythromycin-benzoyl peroxide	1	
FINACEA TOPICAL FOAM	3	
INOVA	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
metronidazole topical	1	
MIRVASO	3	
myorisan	1	
neuac	1	
refissa	1	
rosadan topical cream	1	
rosadan topical gel	1	
rosula cleansing cloths	1	
SOOLANTRA	3	
ss 10-2	1	
sss 10-5	1	
sulfacetamide sodium-sulfur topical cleanser	1	
sulfacetamide sodium-sulfur topical cream	1	
sulfacetamide sodium-sulfur topical lotion	1	
sulfacetamide sodium-sulfur topical pads, medicated 10-5 %	1	
sulfacetamide sodium-sulfur topical suspension	1	
sulfacetamide sod-sulfur-urea topical cleanser	1	
sulfacetamide-sulfur-cleansr23	1	
sulfacleanse 8-4	1	
sulfact na-sul-avobnz-otn-ocsa	1	
TAZORAC	2	
tretinoin (emollient)	1	
tretinoin microspheres	1	
tretinoin topical	1	
VANOXIDE-HC	2	
zenatane	1	
zencia	1	
Topical Anesthetics		
EMLA	3	
ethyl chloride	1	
glydo	1	
lidocaine hcl mucous membrane jelly	1	
lidocaine hcl mucous membrane solution 4 %	1	
lidocaine hcl topical cream 3 %	1	
lidocaine hcl topical lotion	1	
lidocaine hcl-hydrocortisone ac topical	1	
lidocaine topical adhesive patch, medicated	1	
lidocaine topical ointment	1	
lidocaine viscous	1	
lidocaine-prilocaine	1	
LIDOCAINE-TETRACAINE	3	
LIDODERM	2	
lido-k	1	
lidopin topical cream 3 %	1	
lta pre-attached	1	
Topical Antibacterials		
ALTABAX	3	
gentamicin topical	1	
mupirocin	1	
mupirocin calcium	1	
sulfacetamide sodium (acne)	1	
SULFAMYLON	2	
Topical Antifungals		
ciclodan	1	
ciclopirox	1	
ciclopirox-urea-camphor-menthol-euc	1	
clotrimazole-betamethasone	1	
econazole topical	1	
ERTACZO	3	
EXELDERM	3	
ketoconazole topical	1	
NAFTIFINE TOPICAL CREAM 1 %	3	
naftifine topical cream 2 %	1	
NAFTIN TOPICAL CREAM 1 %	3	
NAFTIN TOPICAL GEL	3	
nyamyc	1	
nystatin topical	1	
nystatin-triamcinolone	1	
nystop	1	
oxiconazole	1	
OXISTAT TOPICAL LOTION	3	
PEDIADERM AF	3	
Topical Antivirals		
acyclovir topical	1	
DENAVIR	2	
ZOVIRAX TOPICAL CREAM	2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
Topical Corticosteroids		
ALA-SCALP	2	
alclometasone	1	
amcinonide	1	
apexicon e	1	
betamethasone dipropionate	1	
betamethasone valerate	1	
betamethasone, augmented	1	
clobetasol	1	
clobetasol-emollient	1	
clodan	1	
CLODERM	3	
CORDRAN TAPE SMALL ROLL	3	QL
cormax scalp	1	
desonide	1	
desoximetasone	1	
diflorasone	1	
fluocinolone	1	
fluocinolone and shower cap	1	
fluocinonide	1	
fluocinonide-e	1	
flurandrenolide	1	
fluticasone topical	1	
halobetasol propionate	1	
HALOG	3	
hydrocortisone butyrate	1	
hydrocortisone butyrate-emollient	1	
hydrocortisone topical cream 2.5 %	1	
hydrocortisone topical lotion 2.5 %	1	
hydrocortisone topical ointment 2.5 %	1	
hydrocortisone valerate	1	
mometasone topical	1	
prednicarbate	1	
scalacort	1	
TEXACORT	2	
triamcinolone acetonide topical aerosol	1	
triamcinolone acetonide topical cream	1	
triamcinolone acetonide topical lotion	1	
triamcinolone acetonide topical ointment 0.025 %, 0.1 %, 0.5 %	1	

Drug Name	Tier	Requirements/ Limitations
Topical Enzymes		
SANTYL	3	
Topical Scabicides / Pediculicides		
EURAX	2	
lindane	1	
LYCELLE	3	
malathion	1	
permethrin topical cream	1	
SKLICE	3	
spinosad	1	
ULESFIA	3	
DIAGNOSTICS & MISCELLANEOUS AGENTS		
Anorexiants		
BELVIQ	3	PA
BELVIQ XR	3	PA
diethylpropion	1	PA
phentermine	1	PA
Miscellaneous Agents		
acamprosate	1	
anagrelide	1	
caffeine citrate oral	1	
cevimeline	1	
CHEMET	2	
disulfiram	1	
etidronate disodium	1	
LITHOSTAT	3	
METOPIRONE	2	
midodrine	1	
pilocarpine hcl oral tablet 5 mg	1	
sodium phenylbutyrate	1	
SYPRINE	3	
Smoking Deterrents		
buproban	1	QL
bupropion hcl (smoking deterrent)	1	QL
CHANTIX CONTINUING MONTH BOX	2	QL
CHANTIX ORAL TABLET 0.5 MG	2	QL
CHANTIX STARTING MONTH BOX	2	QL
NICODERM CQ	2	QL
NICORETTE BUCCAL LOZENGE	2	QL
NICOTINE (POLACRILEX) BUCCAL LOZENGE	2	QL

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
nicotine transdermal patch, td daily	1	QL
NICOTROL	2	QL
NICOTROL NS	2	QL
QUIT 2 BUCCAL LOZENGE	2	QL
QUIT 4 BUCCAL LOZENGE	2	QL
EAR, NOSE & THROAT MEDICATIONS		
Miscellaneous Agents		
azelastine nasal	1	
BACTROBAN NASAL	2	
chlorhexidine gluconate mucous membrane	1	
denta 5000 plus	1	
dentagel	1	
fluoridex daily defense	1	
ipratropium bromide nasal	1	
olopatadine nasal	1	
oralone	1	
periogard	1	
pilocarpine hcl oral tablet 7.5 mg	1	
PREVIDENT 5000 BOOSTER PLUS	3	
PREVIDENT 5000 DRY MOUTH	3	
PREVIDENT 5000 ENAMEL PROTECT	3	
PREVIDENT 5000 SENSITIVE	3	
PREVIDENT DENTAL SOLUTION	3	
sf	1	
sf 5000 plus	1	
sodium fluoride dental	1	
triamcinolone acetonide dental	1	
Miscellaneous Otic Preparations		
acetasol hc	1	
acetic acid otic	1	
acetic acid-aluminum acetate	1	
ciprofloxacin hcl otic	1	
fluocinolone acetonide oil	1	
hydrocortisone-acetic acid	1	
ofloxacin otic	1	
oticin	1	
oticin hc (bak free)	1	
Otic Steroid / Antibiotic		
CIPRODEX	3	
CORTISPORIN-TC	3	

Drug Name	Tier	Requirements/ Limitations
neomycin-polymyxin-hc otic	1	
OTOVEL	3	
ENDOCRINE/DIABETES		
Adrenal Hormones		
cortisone	1	
deltasone oral tablet 20 mg	1	
dexamethasone	1	
dexamethasone intensol	1	
DEXPAK 10 DAY	2	
DEXPAK 13 DAY	2	
DEXPAK 6 DAY	2	
fludrocortisone	1	
hydrocortisone oral	1	
MEDROL ORAL TABLET 2 MG	2	
methylprednisolone	1	
millipred dp	1	
millipred oral tablet	1	
prednisolone oral solution	1	
prednisolone sodium phosphate oral solution	1	
prednisolone sodium phosphate oral tablet, disintegrating	1	
prednisone intensol	1	
prednisone oral	1	
veripred 20	1	
Antithyroid Agents		
methimazole oral tablet 10 mg, 5 mg	1	
propylthiouracil	1	
SSKI	2	
Blood Glucose Monitoring Devices & Supplies		
ONETOUCH ULTRA TEST STRIPS	1	QL
ONETOUCH VERIO TEST STRIPS	1	QL
ONETOUCH DELICA LANCING DEV	1	
ONETOUCH SURESOFT LANCING DEV	1	
ONETOUCH DELICA LANCETS	1	QL
ONETOUCH ULTRASOFT LANCETS	2	QL
ONETOUCH ULTRA 2 METER	2	
ONETOUCH ULTRAMINI METER	2	
ONETOUCH VERIO FLEX METER	2	
ONETOUCH VERIO IQ METER	2	
ONETOUCH VERIO SYNC METER	2	
ONETOUCH VERIO SYSTEM	2	

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Drug Name	Tier	Requirements/ Limitations
lancing device	1	
lancets	1	
Insulin Therapy		
HUMULIN R U-500 (CONC) KWIKPEN	3	
HUMULIN R U-500 (CONCENTRATED)	1	
LANTUS VIAL	1	
LANTUS SOLOSTAR	2	
LEVEMIR VIAL	1	
LEVEMIR FLEXTOUCH	2	
NOVOLIN 70/30 VIAL	1	
NOVOLIN N VIAL	1	
NOVOLIN R VIAL	1	
NOVOLOG VIAL	1	
NOVOLOG FLEXPEN	2	
NOVOLOG MIX 70-30 VIAL	1	
NOVOLOG MIX 70-30 FLEXPEN	2	
NOVOLOG PENFILL	2	
TOUJEO SOLOSTAR	2	
TRESIBA FLEXTOUCH U-100	2	
TRESIBA FLEXTOUCH U-200	2	
Miscellaneous Hormones		
ANADROL-50	2	
ANDRODERM	2	PA
ANDROGEL	2	PA
androxy	1	
AXIRON	2	PA
cabergoline	1	QL
calcitonin (salmon)	1	
calcitriol intravenous solution 1 mcg/ml	1	
calcitriol oral	1	
clomiphene citrate	1	
danazol oral	1	
DEPO-TESTOSTERONE	2	PA
desmopressin nasal solution	1	
desmopressin nasal spray, non-aerosol	1	
desmopressin oral	1	
fortical	1	
METHITEST	2	PA
methyltestosterone oral capsule	1	PA
oxandrolone	1	
paricalcitol oral	1	PA

Drug Name	Tier	Requirements/ Limitations
SENSIPAR	2	
SYNAREL	2	
testosterone cypionate	1	PA
testosterone enanthate	1	PA
testosterone transdermal gel 1% in metered-dose pump 1.25 gram/ actuation	1	PA
testosterone transdermal gel in packet	1	PA
Non-Insulin Hypoglycemic Agents		
acarbose	1	
ACTOPLUS MET XR	2	
BYDUREON	2	ST
BYETTA	2	ST
chlorpropamide	1	
CYCLOSET	3	
FARXIGA	3	
glimepiride	1	
glipizide	1	
glipizide-metformin	1	
GLUCAGEN HYPOKIT	2	
GLUCAGON KIT	2	
glyburide micronized	1	
glyburide oral	1	
glyburide-metformin	1	
INVOKAMET	2	
INVOKANA	2	
JANUMET	2	
JANUMET XR	2	
JANUVIA	2	
KOMBIGLYZE XR	2	
metformin oral tablet	1	
metformin oral tablet extended release 24 hour 500 mg, 750 mg	1	
miglitol	1	
nateglinide	1	
ONGLYZA	2	
pioglitazone	1	QL
pioglitazone-glimepiride	1	
pioglitazone-metformin	1	
repaglinide	1	
repaglinide-metformin	1	
RIOMET	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
SYMLINPEN 120	3	PA
SYMLINPEN 60	3	PA
tolazamide	1	
tolbutamide	1	
VICTOZA 2-PAK	2	ST; QL = 9mL/ 30days
VICTOZA 3-PAK	2	ST; QL = 9mL/ 30days
XIGDUO XR	2	
Thyroid Hormones		
levothyroxine oral	1	
levoxyl oral tablet	1	
liothyronine oral	1	
nature-throid	1	
np thyroid tablet 30 mg, 60 mg, 90 mg	1	
unithroid	1	
westhroid oral tablet	1	
GASTROENTEROLOGY		
Antidiarrheals & Antispasmodics		
anaspaz	1	
belladonna alkaloids-opium	1	
belladonna-opium	1	
CUVPOSA	3	
dicyclomine oral capsule	1	
dicyclomine oral solution	1	
dicyclomine oral tablet	1	
diphenoxylate-atropine	1	
ed-spaz	1	
glycopyrrolate oral	1	
hyoscyamine sulfate	1	
hyosyne	1	
methscopolamine oral	1	
oscimin	1	
oscimin sl	1	
oscimin sr	1	
paregoric	1	
phenohytro	1	
propantheline	1	
SYMAX DUOTAB	3	
symax fastabs	1	
symax-sl	1	
symax-sr	1	
Miscellaneous Gastrointestinal Agents		

Drug Name	Tier	Requirements/ Limitations
ACTIGALL	2	
alosetron	1	
AMITIZA	2	
ASACOL HD	2	
balsalazide	1	
bisacodyl oral	1	
budesonide oral	1	
calcium acetate oral capsule	1	
calcium acetate oral tablet 667 mg	1	
CALCIUM ACETATE ORAL TABLET 668 MG (169 MG CALCIUM)	3	
CANASA	2	
citrate of magnesia	1	
colocort	1	
compro	1	
constulose	1	
CREON	2	
cromolyn oral	1	
DELZICOL	2	
dronabinol	1	
eliphos	1	
enulose	1	
FOSRENOL	3	
gavilyte-c	1	
gavilyte-g	1	
gavilyte-h and bisacodyl	1	
gavilyte-n	1	
generlac	1	
granisetron hcl oral	1	QL
hydrocortisone rectal cream	1	
hydrocortisone topical cream with peri-neal applicator	1	
hydrocortisone-pramox-e-pram#1	1	
hydrocortisone-pramoxine rectal cream 2.5-1 % (4g)	1	
KAYEXALATE	2	
kionex	1	
kionex (with sorbitol)	1	
KRISTALOSE	3	
lactulose oral solution 10 gram/15 ml	1	
LIALDA	2	

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Drug Name	Tier	Requirements/ Limitations
lidocaine hcl-hydrocortisone ac rectal cream 3-0.5 %	1	
LIDOCAINE HCL-HYDROCORTISONE AC RECTAL GEL	3	
lidocaine hcl-hydrocortisone ac rectal kit	1	
lidocaine-hydrocortisone-aloe	1	
LINZESS	2	
meclizine oral tablet 12.5 mg, 25 mg	1	
mesalamine rectal	1	
mesalamine with cleansing wipe	1	
metoclopramide hcl oral	1	
milk of magnesia concentrated	1	
MOVANTIK	3	
MOVIPREP	3	
ondansetron	1	
ondansetron hcl oral	1	
OSMOPREP	3	
PANCREAZE	3	
pancrelipase 5000	1	
peg 3350-electrolytes	1	
peg-electrolyte solution	1	
peg-prep	1	
PENTASA	2	
PERTZYE	3	
PHOSLYRA	3	
phosphate laxative oral liquid	1	
polyethylene glycol 3350 oral	1	
pramcort	1	
PREPOPIK	3	
prochlorperazine	1	
prochlorperazine maleate oral	1	
proctosol hc topical	1	
proctozone-hc cream	1	
RECTIV	3	
RELISTOR ORAL	3	
RENAGEL	2	
RENVELA	2	
SFROWASA	2	
sodium polystyrene sulfonate oral	1	
sodium polystyrene sulfonate rectal enema 30 gram/120 ml	1	
SODIUM POLYSTYRENE SULFONATE RECTAL ENEMA 50 GRAM/200 ML	3	
sps (with sorbitol)	1	
sulfasalazine	1	
SUPREP BOWEL PREP KIT	3	
TRANSDERM-SCOP	3	
trilyte with flavor packets	1	
trimethobenzamide oral	1	
ULTRESA	3	
ursodiol	1	
VARUBI	3	
VIOKACE	3	
ZENPEP	3	
Ulcer Therapy		
carafate oral suspension	1	
cimetidine hcl oral	1	
cimetidine tablet 300 mg, 400 mg, 800 mg	1	
esomeprazole magnesium oral capsule 40 mg, delayed release(dr/ec)	1	QL
famotidine oral suspension	1	
misoprostol	1	
NEXIUM PACKET	3	
omeprazole oral capsule, delayed release	1	
pantoprazole oral tablet	1	
PREVACID SOLUTAB	3	ST
rabeprazole	1	
ranitidine hcl oral capsule 300 mg	1	
ranitidine hcl oral syrup	1	
sucralfate oral tablet	1	
IMMUNOLOGY & BIOTECHNOLOGY		
Interferons		
moderiba	1	
moderiba dose pack	1	
ribasphere	1	
ribasphere ribapak	1	
ribavirin oral capsule	1	
ribavirin oral tablet 200 mg	1	
Interleukins		
imiquimod	1	QL
ZYCLARA	2	QL

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
MUSCULOSKELETAL & RHEUMATOLOGY		
Gout Therapy		
allopurinol	1	
COLCRYS	2	
probenecid	1	
probenecid-colchicine	1	
ULORIC	3	PA
Osteoporosis Therapy		
alendronate oral solution	1	
alendronate oral tablet 5 mg, 10 mg	1	QL
alendronate oral tablet 35 mg, 70 mg	1	
ibandronate oral tablet	1	
raloxifene	1	
risedronate oral tablet 5 mg, 35 mg, 150 mg	1	
risedronate oral tablet, delayed release	1	
Other Rheumatologicals		
CUPRIMINE	2	
DEPEN TITRATABS	2	
leflunomide	1	QL
RIDAURA	2	
SAVELLA	2	
OBSTETRICS & GYNECOLOGY		
Diaphragms and Other Non-Oral Contraceptives		
CAYA CONTOURED	3	QL
FC2 FEMALE CONDOM	3	
FEMCAP VAGINAL DEVICE 22 MM	3	
WIDE-SEAL DIAPHRAGM	3	
Estrogens & Progestins		
amabelz	1	
camila	1	QL
COMBIPATCH	2	
covaryx	1	
covaryx h.s.	1	
CRINONE	2	
deblitane	1	QL
DIVIGEL	3	
DUAVEE	3	
eemt	1	
eemt hs	1	
ELESTRIN	3	

Drug Name	Tier	Requirements/ Limitations
ENDOMETRIN	3	
errin	1	QL
ESTRACE VAGINAL	2	
estradiol	1	
estradiol-norethindrone acetate	1	
ESTRING	2	QL
ESTROGEL	3	
estrogens-methyltestosterone	1	
estropipate	1	
EVAMIST	3	
FEMHRT LOW DOSE	2	
FEMRING	2	QL
fyavolv	1	
heather	1	QL
jencycla	1	QL
jevantique lo	1	
jinteli	1	
jolivette	1	QL
lopreeza	1	
lyza	1	QL
medroxyprogesterone intramuscular	1	QL
medroxyprogesterone oral	1	
mimvey	1	
mimvey lo	1	
nora-be	1	QL
norethindrone (contraceptive)	1	QL
norethindrone acetate	1	
norethindrone ac-eth estradiol oral tablet 0.5-2.5 mg-mcg, 1-5 mg-mcg	1	
norlyroc	1	QL
PREFEST	3	
PREMARIN ORAL	2	
PREMARIN VAGINAL	2	
PREMPHASE	2	
PREMPRO	2	
progesterone micronized	1	
sharobel	1	QL
VAGIFEM	2	
VIVELLE-DOT	2	
Miscellaneous OB/GYN		
AVC VAGINAL	2	
CLEOCIN VAGINAL	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
clindamycin phosphate vaginal	1	
CLINDESSE	3	
CONCEPTROL	3	
fem ph	1	
GYNAZOLE-1	3	
isoxsuprine	1	
metronidazole vaginal	1	
NUVARING	2	QL
NUVESSA	3	
OSPHENA	3	
TERAZOL 3 VAGINAL CREAM	3	QL
TERAZOL 7	3	QL
terconazole	1	QL
TODAY CONTRACEPTIVE SPONGE	3	
tranexamic acid oral	1	QL
vaginal contraceptive foam	1	
vandazole	1	
VCF CONTRACEPTIVE FILM	2	
VCF CONTRACEPTIVE GEL	3	
xulane	1	QL
Oral Contraceptives & Related Agents		
altavera	1	QL
alyacen	1	QL
amethia	1	QL
apri	1	QL
aranelle	1	QL
ashlyna	1	QL
aviane	1	QL
azurette	1	QL
camila	1	QL
camrese	1	QL
caziant	1	QL
cesia	1	QL
chateal	1	QL
cryselle	1	QL
cyclafem	1	QL
dasetta	1	QL
daysee	1	QL
desogestrel/eth estradiol	1	QL
drosperinone	1	QL
elinest	1	QL

Drug Name	Tier	Requirements/ Limitations
emoquette	1	QL
enpresse	1	QL
enskyce	1	QL
errin	1	QL
estarylla	1	QL
falminda	1	QL
gianvi	1	QL
gildess	1	QL
gildess FE	1	QL
heather	1	QL
introvale	1	QL
jolessa	1	QL
jolivette	1	QL
junel	1	QL
junel FE (28)	1	QL
kariva	1	QL
kelnor	1	QL
kurvelo	1	QL
leena	1	QL
levonor	1	QL
levonorgest/eth estradiol	1	QL
levora	1	QL
loryna	1	QL
low-ogestrel	1	QL
lutera	1	QL
marlissa	1	QL
microgestin	1	QL
microgestin FE (28)	1	QL
mono-linyah	1	QL
mononessa	1	QL
myzilra	1	QL
necon	1	QL
nikki	1	QL
nora-be	1	QL
norethin/eth estradiol	1	QL
norethin/eth estradiol FE	1	QL
norethindrone	1	QL
norgest/eth estradiol	1	QL
nortrel	1	QL
ocella	1	QL
orsythia	1	QL

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
portia	1	QL
previfem	1	QL
quasense	1	QL
reclipsen	1	QL
solia	1	QL
sprintec	1	QL
sronyx	1	QL
syeda	1	QL
tri-estarylla	1	QL
tri-linyah	1	QL
tri-lo-estarylla	1	QL
tri-lo-marzia	1	QL
tri-lo-sprintec	1	QL
trinessa	1	QL
trinessa lo	1	QL
tri-previfem	1	QL
tri-sprintec	1	QL
trivora	1	QL
velivet	1	QL
vesture	1	QL
viorelle	1	QL
wera	1	QL
zarah	1	QL
zovia	1	QL
Oxytocics		
methergine	1	
methylergonovine oral	1	
OPHTHALMOLOGY		
Antibiotics		
ak-poly-bac	1	
ALODOX	3	
AZASITE	2	
bacitracin ophthalmic	1	
bacitracin-polymyxin b ophthalmic	1	
BETADINE OPHTHALMIC PREP	3	
CILOXAN OPHTHALMIC OINTMENT	2	
ciprofloxacin hcl ophthalmic	1	
erythromycin ophthalmic	1	
gatifloxacin	1	
gentak ophthalmic ointment	1	
gentamicin ophthalmic	1	

Drug Name	Tier	Requirements/ Limitations
levofloxacin ophthalmic	1	
NATACYN	3	
neomycin-bacitracin-polymyxin	1	
neomycin-polymyxin-gramicidin	1	
neo-polycin	1	
NEOSPORIN (NEO-POLYM-GRAMICID)	2	
ofloxacin ophthalmic	1	
polycin	1	
polymyxin b sulf-trimethoprim	1	
tobramycin	1	
TOBREX OPHTHALMIC OINTMENT	2	
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levobunolol ophthalmic drops 0.5 %	1	
metipranolol	1	
timolol maleate ophthalmic	1	
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cyclopentolate	1	
homatropaire	1	
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pilocarpine hcl ophthalmic drops	1	
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altacaine	1	
altafluor	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
azelastine ophthalmic	1	
cromolyn ophthalmic	1	
epinastine	1	
flucaine	1	
fluorescein-benoxinate	1	
fluorescein-proparacaine	1	
flurox	1	
olopatadine ophthalmic	1	
parcaine	1	
PATADAY	2	
proparacaine	1	
RESTASIS	2	
tetcaine	1	
tetracaine hcl	1	
tetracaine hcl (pf) ophthalmic	1	
Non-Steroidal Anti-Inflammatory Agents		
ACUVAIL (PF)	2	
bromfenac	1	
diclofenac sodium ophthalmic	1	
flurbiprofen sodium	1	
ILEVRO	2	
ketorolac ophthalmic	1	
Oral Drugs for Glaucoma		
acetazolamide	1	
methazolamide oral	1	
Other Glaucoma Drugs		
AZOPT	3	
bimatoprost ophthalmic	1	
COMBIGAN	3	
COSOPT	3	
COSOPT (PF)	3	
dorzolamide	1	
dorzolamide-timolol	1	
latanoprost	1	
LUMIGAN OPHTHALMIC DROPS 0.01 %	2	ST
RESCULA	2	ST
SIMBRINZA	3	
travoprost (benzalkonium)	1	
Steroid-Antibiotic Combinations		
neomycin-bacitracin-poly-hc	1	
neomycin-polymyxin b-dexameth	1	
neomycin-polymyxin-hc ophthalmic	1	
neo-polycin hc	1	
PRED-G	2	
PRED-G S.O.P.	2	
TOBRADEX OPHTHALMIC OINTMENT	3	
TOBRADEX ST	2	
tobramycin-dexamethasone	1	
ZYLET	3	
Steroids		
dexamethasone sodium phosphate ophthalmic	1	
DUREZOL	2	
FLAREX	2	
fluorometholone	1	
FML LIQUIFILM	2	
FML S.O.P.	2	
LOTEMAX	2	
MAXIDEX	2	
PRED MILD	2	
prednisolone acetate	1	
prednisolone sodium phosphate oph-thalmic	1	
Steroid-Sulfonamide Combinations		
BLEPHAMIDE	2	
BLEPHAMIDE S.O.P.	2	
sulfacetamide-prednisolone	1	
Sulfonamides		
sulfacetamide sodium ophthalmic	1	
Sympathomimetics		
ALPHAGAN P	2	
apraclonidine	1	
brimonidine	1	
IOPIDINE	3	
Vasoconstrictor Decongestants		
naphazoline	1	
phenylephrine hcl ophthalmic	1	
RESPIRATORY, ALLERGY, COUGH & COLD		
Antihistamine & Antiallergenic Agents		
adrenalin injection	1	
arbinoxa	1	
carbinoxamine maleate	1	
cetirizine oral solution 1 mg/ml	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
clemastine oral syrup	1	
clemastine oral tablet 2.68 mg	1	
cyproheptadine	1	
epinephrine injection auto-injector 0.15 mg/0.15 ml, 0.3 mg/0.3 ml	1	QL
epinephrine injection solution	1	
epinephrine injection syringe 0.1 mg/ml	1	
EPIPEN 2-PAK	2	QL
EPIPEN JR 2-PAK	2	QL
hydroxyzine hcl oral solution 10 mg/5 ml	1	
hydroxyzine hcl oral tablet	1	
hydroxyzine pamoate	1	
phenadoz	1	
phenergan rectal	1	
promethazine oral	1	
promethazine rectal	1	
promethegan	1	
Cough & Cold Therapy		
benzonatate	1	
BROMFED DM	2	
brompheniramine-pseudoeph-dm oral syrup	1	
CAPCOF	3	
centergy	1	
cheratussin ac	1	
cheratussin dac	1	
codeine-guaifenesin	1	
FLOWTUSS	3	
guaifenesin ac	1	
guaifenesin dac	1	
HISTEX-AC	3	
HYCOFENIX	3	
hydrocodone-chlorpheniramine	1	
hydrocodone-cpm-pseudoephedrine	1	
hydrocodone-homatropine oral syrup 5-1.5 mg/5 ml	1	
hydrocodone-homatropine oral tablet	1	
hydromet	1	
iophen c-nr	1	
lortuss ex oral syrup	1	

Drug Name	Tier	Requirements/ Limitations
m-clear wc	1	
phenylhistine dh	1	
poly-tussin d	1	
promethazine vc	1	
promethazine vc-codeine	1	
promethazine-codeine	1	
promethazine-dm	1	
promethazine-phenylephrine-codeine	1	
PRO-RED AC (W/ DEXCHLORPHENIR)	3	
relcof c	1	
RESPA-AR	2	
REZIRA	3	
r-tanna	1	
rydex	1	
tusnel c	1	
TUSNEL PEDIATRIC ORAL LIQUID	3	
tussigon	1	
TUZISTRA XR	3	
virtussin ac	1	
virtussin dac	1	
Pulmonary Agents		
acetylcysteine	1	
ADVAIR DISKUS	2	QL
ADVAIR HFA	2	
albuterol sulfate inhalation solution for nebulization	1	
albuterol sulfate oral	1	
ANORO ELLIPTA	2	
ARCAPTA NEOHALER	3	
ARNUITY ELLIPTA	2	
ATROVENT HFA	2	
BREO ELLIPTA	2	
budesonide inhalation	1	
budesonide nasal	1	
COMBIVENT RESPIMAT	2	
cromolyn inhalation	1	
DALIRESP	2	
DULERA	2	
DYMISTA	3	
FLOVENT DISKUS	2	
FLOVENT HFA	2	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
flunisolide nasal spray, non-aerosol 25 mcg (0.025 %)	1	
fluticasone nasal	1	QL
FORADIL AEROLIZER	2	
HYPER-SAL	3	
INCRUSE ELLIPTA	3	
ipratropium bromide inhalation	1	
ipratropium-albuterol	1	
levalbuterol hcl inhalation solution for nebulization	1	
metaproterenol oral	1	
mometasone nasal	1	QL
montelukast	1	
NEBUSAL	3	
PERFOROMIST	2	
PROAIR HFA	2	QL
PROAIR RESPICLICK	2	
PULMICORT	3	
PULMICORT FLEXHALER	2	
pulmosal	1	
QVAR	2	
RHINOCORT AQUA	3	
SEEBRI NEOHALER	3	
SEREVENT DISKUS	2	
sildenafil	1	PA
sodium chloride inhalation solution for nebulization 3 %, 7 %, 10 %	1	
SPIRIVA RESPIMAT	3	
SPIRIVA WITH HANDIHALER	2	
STIOLTO RESPIMAT	2	
SYMBICORT	2	
terbutaline oral	1	
THEO-24	3	
theochron	1	
theophylline oral solution	1	
theophylline oral tablet ext-release 12 hr	1	
theophylline oral tablet ext- release 24 hr	1	
triamcinolone acetonide nasal	1	QL
TUDORZA PRESSAIR	3	
VENTOLIN HFA	2	
VOSPIRE ER	2	
zafirlukast	1	
ZYFLO	2	

Drug Name	Tier	Requirements/ Limitations
ZYFLO CR	3	
UROLOGICALS		
Anticholinergics & Antispasmodics		
darifenacin	1	
DETROL LA	2	
flavoxate	1	
MYRBETRIQ	2	
oxybutynin chloride oral	1	
tolterodine	1	
TOVIAZ	2	
trospium	1	
VESICARE	2	
Benign Prostatic Hyperplasia (BPH) Therapy		
alfuzosin	1	
dutasteride	1	
dutasteride-tamsulosin	1	
finasteride oral tablet 5 mg	1	
tamsulosin	1	
Cholinergic Stimulants		
bethanechol chloride	1	
Miscellaneous Urologicals		
cytra k crystals	1	
cytra-2	1	
cytra-3	1	
cytra-k	1	
ELMIRON	2	
hyolev mb	1	
hyophen	1	
INDIOMIN MB	3	
K-PHOS NO 2	2	
K-PHOS ORIGINAL	2	
methen-sod phos-meth blue-hyos	1	
ORACIT	2	
phosphasal	1	
pot,sodium citrate-citric acid	1	
potassium citrate	1	
potassium citrate-citric acid	1	
sodium citrate-citric acid	1	
tricitrates	1	
ur n-c	1	
uramit mb	1	
URELLE	3	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

Drug Name	Tier	Requirements/ Limitations
uretron d-s oral tablet 81.6-10.8-40.8 mg	1	
URIBEL	3	
urimar-t	1	
urin ds	1	
uro-458	1	
uro-blue	1	
urogesic-blue	1	
uro-l	1	
urolet mb	1	
uro-mp	1	
urophen mb	1	
UROQID-ACID NO.2	3	
uryl	1	
ustell	1	
utira-c	1	
virtrate-2	1	
virtrate-3	1	
virtrate-k	1	
Urinary Anesthetics		
phenazopyridine tablet 100 mg, 200 mg	1	
VITAMINS, HEMATINICS & ELECTROLYTES		
Electrolytes		
calcium 500 with d	1	
calcium citrate + d	1	
effer-k oral tablet, effervescent 25 meq	1	
k-effervescent	1	
klor-con	1	
klor-con 10	1	
klor-con 8	1	
klor-con m10	1	
klor-con m15	1	
klor-con m20	1	
klor-con sprinkle	1	
KLOR-CON/25	2	
klor-con/ef	1	
k-phos-neutral	1	
k-sol	1	
K-TAB ORAL TABLET EXTENDED RELEASE 10 MEQ, 20 MEQ	3	
k-tab oral tablet extended release 8 meq	1	
lugols oral	1	

Drug Name	Tier	Requirements/ Limitations
phospha 250 neutral	1	
potassium bicarb and chloride	1	
potassium bicarb-citric acid	1	
potassium chloride oral	1	
strong iodine oral	1	
virt-phos 250 neutral	1	
Vitamins & Hematinics		
b complex-vitamin b12	1	
balanced b-100 complex oral tablet extended release 100 mg	1	
b-complex with vitamin c oral tablet	1	
classic prenatal	1	
fluor-a-day (with xylitol)	1	
fluoritab oral tablet,chewable	1	
FLURA-DROPS	2	
folic acid oral tablet	1	
foltabs 800	1	
inatal advance	1	
inatal ultra	1	
lozi-flur	1	
ludent fluoride	1	
multi-vit with fluoride-iron	1	
multi-vitamin with fluoride oral drops	1	
multi-vitamin with fluoride oral tablet, chewable 0.25 mg, 0.5 mg	1	
multivitamins with fluoride oral tablet, chewable 0.25 mg, 0.5 mg	1	
mvc-fluoride oral tablet, chewable 0.25 mg, 0.5 mg	1	
mynatal	1	
mynatal advance	1	
mynatal plus	1	
mynatal-z	1	
natural b-100 complex	1	
one daily prenatal oral combo pack 28-800-440 mg-mcg-mg	1	
pnv 29-1	1	
poly-vitamin with iron	1	
prenatabs fa	1	
prenatabs rx	1	

You can find information on what the symbols and abbreviations on this table mean by going to the beginning of this table.

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Drug Name	Tier	Requirements/ Limitations
prenatal complete	1	
prenatal formula tablet 28 mg 800 mcg	1	
prenatal one daily	1	
prenatal oral tablet 28 mg iron- 800 mcg	1	
prenatal plus	1	
prenatal plus (calcium carb)	1	
prenatal vit#96-ferrous fum-fa	1	
prenatal vitamin oral tablet , 27-0.8 mg, 28 mg iron- 800 mcg	1	
prenatal vitamin plus low iron	1	
preplus	1	
pretab	1	
rena-vite	1	
sodium fluoride oral drops	1	
sodium fluoride oral tablet, chewable	1	
stress formula	1	
stress formula with iron	1	
stress formula with iron(sulf)	1	
trinatal gt	1	
trinatal rx 1	1	
trinate	1	
triple vitamin with fluoride	1	
tri-vit with fluoride and iron	1	
tri-vitamin with fluoride	1	
vinate one	1	
vinate ultra	1	
virt-advance	1	
virt-nate	1	
virt-vite gt	1	
vit b complex-folic acid oral tablet	1	
vitamin d3 oral tablet 400 unit	1	
vitamins a,c,d and fluoride	1	
vol-nate	1	
vol-plus	1	
vol-tab rx	1	

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