



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, visit [sanfordhealthplan.com/sbcfinder](https://www.sanfordhealthplan.com/sbcfinder) or call 1-800-752-5863 (toll free) | TTY/TDD: 711. 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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-752-5863 to request a copy.

| Important Questions   | Answers  | Why This Matters:   |
|---|--|---|
| <b>What is the overall deductible?</b>                                | For <u>network providers</u> <b>\$200</b> individual / <b>\$400</b> family.<br><b>No out of network coverage.</b><br><b>Copays do not apply to deductible.</b> | Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family <u>deductible</u> .   |
| <b>Are there services covered before you meet your deductible?</b>    | Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .   | This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive services</u> without cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .                     |
| <b>Are there other deductibles for specific services?</b>             | No.  | You don't have to meet <u>deductibles</u> for specific services.  |
| <b>What is the out-of-pocket limit for this plan?</b>                 | For <u>network providers</u> <b>\$1,250</b> individual / <b>\$2,500</b> family.<br><b>No out of network coverage.</b>  | The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.   |
| <b>What is not included in the out-of-pocket limit for this plan?</b> | <u>Premium</u> , <u>balance-billing</u> charges (unless balanced billing is prohibited), and health care this <u>plan</u> doesn't cover.                       | Even though you pay these expenses, they don't count toward the out-of-pocket limit.  |
| <b>Will you pay less if you use a network provider?</b>               | Yes. See <a href="https://www.sanfordhealthplan.com">www.sanfordhealthplan.com</a> or call 1-800-752-5863 for a list of <u>network providers</u> .             | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a provider in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (balance billing). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before you get services. |
| <b>Do you need a referral to see a specialist?</b>                    | No.  | You can see the in-network <u>specialist</u> you choose without a <u>referral</u> .   |



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  |
|---|--|---|---|---|
|   |  | <u>Network provider</u><br>(You will pay the least) | <u>Out-of-network provider</u><br>(You will pay the most) |   |
| <b>If you visit a health care provider's office or clinic</b> | Primary care visit to treat an injury or illness | \$5 <u>copay</u> / office visit                     | Not covered   | None  |
|   | Chiropractic visit                               | \$5 <u>copay</u> / office visit                     | Not covered   | Office visit <u>copay</u> applies to the office visit charge and manual manipulation only. All other eligible modalities and therapies are subject to <u>deductible</u> / <u>coinsurance</u> . Limited to 20 visits per calendar year.  |
|   | <u>Specialist</u> visit                          | \$20 <u>copay</u> / office visit                    | Not covered   | None  |
|   | <u>Preventive care/screening/immunization</u>    | No charge   | Not covered   | You may have to pay for services that aren't on the <u>preventive</u> health guidelines. Ask your <u>provider</u> if these services you need are preventive. Then check what your <u>plan</u> will pay for.   |
| <b>If you have a test</b>                                     | <u>Diagnostic test</u> (x-ray, blood work)       | No charge   | Not covered   | Some diagnostic x-rays, ultrasounds, specimens, and blood work done in an office visit setting that occur on the same date of service are included in your office visit copay. Additional services may be subject to <u>deductible</u> / <u>coinsurance</u> . Contact the Plan for full details on included benefits. |
|   | Imaging (CT/PET scans, MRIs)                     | 10% <u>coinsurance</u> after <u>deductible</u>      | Not covered   | Prior authorization may be required.  |

| Common Medical Event   | Services You May Need                          | What You Will Pay                                   |   | Limitations, Exceptions, & Other Important Information   |
|--|--|---|---|--|
|  |  | <u>Network provider</u><br>(You will pay the least) | <u>Out-of-network provider</u><br>(You will pay the most) |  |
| <b>If you need drugs to treat your illness or condition</b><br>More information about <b>prescription drug coverage</b> is available at <a href="http://sanfordhealthplan.com/pharmacy">sanfordhealthplan.com/pharmacy</a> | Generic drugs less than \$6                    | \$0 <u>copay</u> / prescription                     | Not covered   | Covers up to a 30-day supply. Generic cost is based on total drug cost per 30-day supply. Brand name drugs with generic equivalents require additional cost share. Difference in cost does not apply to <u>deductible</u> or <u>out-of-pocket limit</u> . There are no limitations or restrictions for use of manufacturer coupons if used in conjunction with our current benefit offering. If the cost of the prescription falls under the copay amount, you will pay the least. Refer to your <u>Formulary</u> to determine which benefit applies to your medication. |
|  | Generic drugs greater or equal to \$6          | \$3 <u>copay</u> / prescription                     | Not covered   |  |
|  | Preferred brand drugs                          | \$20 <u>copay</u> / prescription                    | Not covered   |  |
|  | Non-preferred brand drugs                      | \$40 <u>copay</u> / prescription                    | Not covered   |  |
|  | <u>Specialty drugs</u>                         | 10% <u>coinsurance</u> after <u>deductible</u>      | Not covered   |  |
| <b>If you have outpatient surgery</b>  | Facility fee (e.g., ambulatory surgery center) | 10% <u>coinsurance</u> after <u>deductible</u>      | Not covered   | Certain outpatient services may require authorization (pre-approval) by the Plan. For a list of services, see the Prior Authorization list at <a href="http://sanfordhealthplan.com">sanfordhealthplan.com</a> .   |
|  | Physician/surgeon fees                         | 10% <u>coinsurance</u> after <u>deductible</u>      | Not covered   | None   |
| <b>If you need immediate medical attention</b>   | <u>Emergency room care</u>                     | 10% <u>coinsurance</u> after <u>deductible</u>      | 10% <u>coinsurance</u> after <u>deductible</u>            | None   |
|  | <u>Emergency medical transportation</u>        | 10% <u>coinsurance</u> after <u>deductible</u>      | 10% <u>coinsurance</u> after <u>deductible</u>            | None   |
|  | <u>Urgent care</u>                             | \$15 <u>copay</u> / office visit                    | \$15 <u>copay</u> / office visit                          | Additional services may be subject to <u>deductible</u> / <u>coinsurance</u> .   |

| Common Medical Event  | Services You May Need                     | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information  |
|---|---|--|---|---|
|   |   | <u>Network provider</u><br>(You will pay the least)  | <u>Out-of-network provider</u><br>(You will pay the most) |   |
| If you have a hospital stay   | Facility fee (e.g., hospital room)        | 10% <u>coinsurance</u> after <u>deductible</u>   | Not covered   | Prior authorization required.   |
|   | Physician/surgeon fees                    | 10% <u>coinsurance</u> after <u>deductible</u>   | Not covered   | None  |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services                       | \$5 <u>copay</u> / office visit and 10% <u>coinsurance</u> for other outpatient services after <u>deductible</u> | Not covered   | None  |
|   | Inpatient services                        | 10% <u>coinsurance</u> after <u>deductible</u>   | Not covered   | Prior authorization required.   |
| If you are pregnant   | Office visits                             | No charge  | Not covered   | Cost sharing does not apply to routine prenatal and postnatal-care and certain <u>preventive services</u> . Depending on the type of services <u>copayment</u> or <u>coinsurance</u> may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound). |
|   | Childbirth/delivery professional services | 10% <u>coinsurance</u> after <u>deductible</u>   | Not covered   |   |
|   | Childbirth/delivery facility services     | 10% <u>coinsurance</u> after <u>deductible</u>   | Not covered   |   |

| Common Medical Event   | Services You May Need            | What You Will Pay  |   | Limitations, Exceptions, & Other Important Information   |
|--|----------------------------------|--|---|--|
|  |                                  | <u>Network provider</u><br>(You will pay the least)  | <u>Out-of-network provider</u><br>(You will pay the most) |  |
| If you need help recovering or have other special health needs | <u>Home health care</u>          | 10% <u>coinsurance</u> after <u>deductible</u>   | Not covered   | Prior authorization required. Limited to 40 visits per calendar year.  |
|  | <u>Rehabilitation services</u>   | \$5 <u>copay</u> / office visit and 10% <u>coinsurance</u> for other outpatient services after <u>deductible</u> | Not covered   | Office visit <u>copay</u> covers evaluation. Therapies are subject to <u>deductible</u> / <u>coinsurance</u> . Limited to 30 visits per calendar year. |
|  | <u>Habilitation services</u>     | \$5 <u>copay</u> / office visit and 10% <u>coinsurance</u> for other outpatient services after <u>deductible</u> | Not covered   | Office visit <u>copay</u> covers evaluation. Therapies are subject to <u>deductible</u> / <u>coinsurance</u> . Limited to 30 visits per calendar year. |
|  | <u>Skilled nursing care</u>      | 10% <u>coinsurance</u> after <u>deductible</u>   | Not covered   | Prior authorization required. Limited to 30 days in any consecutive 12-month period.   |
|  | <u>Durable medical equipment</u> | 10% <u>coinsurance</u> after <u>deductible</u>   | Not covered   | Prior authorization may be required.   |
|  | <u>Hospice services</u>          | 10% <u>coinsurance</u> after <u>deductible</u>   | Not covered   | None   |

| Common Medical Event                   | Services You May Need      | What You Will Pay                                   |   | Limitations, Exceptions, & Other Important Information   |
|--|----------------------------|---|---|--|
|  |                            | <u>Network provider</u><br>(You will pay the least) | <u>Out-of-network provider</u><br>(You will pay the most) |  |
| If your child needs dental or eye care | Children's eye exam        | No charge   | Not covered   | Limited to 1 visit per calendar year. Benefit ends at the end of the month when the member turns 19.   |
|  | Children's glasses         | 10% <u>coinsurance</u> after <u>deductible</u>      | Not covered   | Limited to 1 frame every other year. Lenses or contact lenses limited to 1 item annually. Benefit ends at the end of the month when the member turns 19.   |
|  | Children's dental check-up | No charge   | Not covered   | Limited to 2 routine check-up visits per calendar year. Preventive, emergency, and routine coverage available for members up to age 19. See your plan document for eligible services. Certain dental services may require authorization (pre-approval) by the plan. For a list of services, see the Prior Authorization list at <a href="http://sanfordhealthplan.com">sanfordhealthplan.com</a> . |

## 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.)

- |                    |                         |  |
|--------------------|-------------------------|--|
| • Abortion         | • Dental care (Adult)   | • Non-emergency care when traveling outside the U.S. |
| • Acupuncture      | • Infertility treatment | • Routine eye care (Adult)                           |
| • Cosmetic surgery | • Long-term care        | • 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 | • Hearing aids | • Private-duty nursing |
| • Chiropractic Care |                | • Routine foot care    |

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272. 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](http://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 on how to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Sanford Health Plan/Appeals & Complaints at 1-800-752-5863 or contact the North Dakota Insurance Department at 1-800-247-0560.

### Does this [plan](#) provide Minimum Essential Coverage? **Yes.**

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

### Does this [plan](#) meet Minimum Value Standards? **Not Applicable.**

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 1-800-892-0675 (*toll-free*).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-892-0675 (*toll-free*).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-892-0675 (*toll-free*).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-892-0675 (*toll-free*).

————— *To see examples of how this 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 <u>plan's</u> overall <u>deductible</u> | \$200 |
| ■ <u>Specialist copayment</u>                 | \$20  |
| ■ <u>Hospital (facility) coinsurance</u>      | 10%   |
| ■ <u>Other coinsurance</u>                    | 10%   |

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*)

|  |                 |
|--|-----------------|
| <b>Total Example Cost</b>              | <b>\$12,700</b> |
| <b>In this example, Peg would pay:</b> |                 |
| <i>Cost Sharing</i>                    |                 |
| <u>Deductibles</u>                     | \$200           |
| <u>Copayments</u>                      | \$10            |
| <u>Coinsurance</u>                     | \$800           |
| <i>What isn't covered</i>              |                 |
| Limits or exclusions                   | \$60            |
| <b>The total Peg would pay is</b>      | <b>\$1,070</b>  |

### Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

|   |       |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$200 |
| ■ <u>Specialist copayment</u>                 | \$20  |
| ■ <u>Hospital (facility) coinsurance</u>      | 10%   |
| ■ <u>Other coinsurance</u>                    | 10%   |

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*)

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$5,600</b> |
| <b>In this example, Joe would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | \$40           |
| <u>Copayments</u>                      | \$400          |
| <u>Coinsurance</u>                     | \$0            |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$20           |
| <b>The total Joe would pay is</b>      | <b>\$460</b>   |

### Mia's Simple Fracture

(in-network emergency room visit and follow up care)

|   |       |
|---|-------|
| ■ The <u>plan's</u> overall <u>deductible</u> | \$200 |
| ■ <u>Specialist copayment</u>                 | \$20  |
| ■ <u>Hospital (facility) coinsurance</u>      | 10%   |
| ■ <u>Other coinsurance</u>                    | 10%   |

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)  
Diagnostic test (*x-ray*)  
Durable medical equipment (*crutches*)  
Rehabilitation services (*physical therapy*)

|  |                |
|--|----------------|
| <b>Total Example Cost</b>              | <b>\$2,800</b> |
| <b>In this example, Mia would pay:</b> |                |
| <i>Cost Sharing</i>                    |                |
| <u>Deductibles</u>                     | \$200          |
| <u>Copayments</u>                      | \$70           |
| <u>Coinsurance</u>                     | \$200          |
| <i>What isn't covered</i>              |                |
| Limits or exclusions                   | \$0            |
| <b>The total Mia would pay is</b>      | <b>\$470</b>   |

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



## 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 Sanford Health Plan at (800) 752-5863 | TTY: 711.

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, you can file a grievance with the Civil Rights Coordinator at 300 Cherapa Place #201, Sioux Falls, SD 57103, call (800) 325-9402 | TTY: 711, fax (605) 328-6812, or e-mail [compliancehotline@sanfordhealth.org](mailto:compliancehotline@sanfordhealth.org). You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the US 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: US Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, TTY/TDD (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 any language other than English, please call **1-800-752-5863** | TTY: 711.

If you have any questions, for example, about your benefits, a document, or how Sanford Health Plan pays for your care, please call us.

**Spanish:** Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Sanford Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-927-2969.

**Hmong:** Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Sanford Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-923-3519.

**Cushite:** Isin yookan namni biraa isin deeggartan Sanford Health Plan irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-927-2968 tiin bilbilaa.

**Vietnamese:** Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Sanford Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-927-2973.

**Chinese (Mandarin):** 如果您, 或您正在幫助的人, 有關於 Sanford Health Plan 方面的問題, 您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話, 請致電 1-844-923-3524。

**German:** Falls Sie oder jemand, dem Sie helfen, Fragen zum Sanford Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-923-3517 an.

