SANFORD HEALTH PLAN

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

**Simplicity Individual Gold $1,750 | South Dakota**

**Coverage Period Beginning on or after: 01/01/2024**

**Coverage for:** Individual + Family | **Plan Type:** PPO | 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, visit **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: |
|---|---|---|
| **What is the overall deductible?** | For network providers **$1,750** individual / **$3,500** family.<br>For out-of-network providers **$3,500** individual / **$7,000** family.<br>**Copays do not apply to deductible.** | Generally, you must pay all of the costs from 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 and primary 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 https://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 **$8,450** individual / **$16,900** family.<br>For out-of-network providers **$16,900** individual / **$33,800** 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 for this plan?** | Premium, balance-billing charges (unless balanced billing is prohibited), 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.com** or call 1-800-752-5863 for a list of network providers. | You will pay the least if you use a provider in the Sanford Preferred network. You pay more if you use a provider in the Affiliated 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.
**Sanford Preferred Providers:** Sanford Health Practitioners and/or Facilities. With Sanford Preferred Providers, you will pay Tier-1 In-Network Benefits.
**Affiliated Providers:** All other In-Network Practitioners and/or Facilities. With Affiliated Providers, you will pay Tier-2 In-Network Benefits.

| 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 | **Sanford Preferred:** $15 copay / office visit **Affiliated:** $35 copay / office visit | 50% coinsurance after deductible | None |
| | Chiropractic visit | **Sanford Preferred or Affiliated:** $15 copay / office visit | 50% coinsurance after deductible | Office visit copay applies to the office visit charge and manual manipulation only. All other eligible modalities and therapies are subject to deductible / coinsurance. |
| | Specialist visit | **Sanford Preferred:** $25 copay / office visit **Affiliated:** $45 copay / office visit | 50% coinsurance after deductible | None |
| | Preventive care/screening/ immunization | **Sanford Preferred or Affiliated:** No charge | 50% coinsurance after deductible | You may have to pay for services that aren't part of the preventive health guidelines. Ask your provider if these services you need are preventive. Then check what your plan will pay for. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | **Sanford Preferred or Affiliated:** $15 copay | 50% coinsurance after deductible | Certain services may be subject to deductible / coinsurance. For full details, refer to your plan document. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance after deductible | 50% coinsurance after deductible | Prior authorization may be required. |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at sanfordhealthplan.com/pharmacy | Generic drugs less than $6 | $0 copay / 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 or biosimilar alternatives require additional cost share. Difference in cost does not apply to deductible or out-of-pocket limit. 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 Formulary to determine which benefit applies to your medication. |
| | Generic drugs greater or equal to $6 | $15 copay / prescription | Not covered | |
| | Preferred brand drugs | $30 copay / prescription | Not covered | |
| | Non-preferred brand drugs | $125 copay / prescription | Not covered | |
| | Generic specialty drugs | $15 copay / prescription | Not covered | |
| | Preferred specialty drugs | 30% coinsurance after deductible | Not covered | |
| | Non-preferred specialty drugs | 50% coinsurance after deductible | 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) | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | Certain outpatient services may require authorization (pre-approval) by the Plan. For a list of services, see the Prior Authorization list at sanfordhealthplan.com. |
| | Physician/surgeon fees | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | None |
| **If you need immediate medical attention** | Emergency room care | 30% coinsurance after deductible | 30% coinsurance after deductible | None |
| | Emergency medical transportation | 30% coinsurance after deductible | 30% coinsurance after deductible | None |
| | Urgent care | $30 copay / office visit | $30 copay / office visit | Additional services may be subject to deductible / coinsurance. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | Prior authorization required. |
| | Physician/surgeon fees | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | None |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | **Sanford Preferred or Affiliated:** $15 copay / office visit Other Outpatient Services 30% coinsurance after deductible. | 50% coinsurance after deductible | None |
| | Inpatient services | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | Prior authorization required. |
| **If you are pregnant** | Office visits | No charge | 50% coinsurance after deductible | Cost sharing does not apply to routine prenatal and postnatal-care and certain 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 | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | |
| | Childbirth/delivery facility services | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | |

| 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 | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | Prior authorization required. |
| | Rehabilitation services | **Sanford Preferred or Affiliated:** $15 copay / office visit Other Outpatient Services 30% coinsurance after deductible | 50% coinsurance after deductible | Office visit copay covers evaluation. |
| | Habilitation services | **Sanford Preferred or Affiliated:** $15 copay / office visit Other Outpatient Services 30% coinsurance after deductible | 50% coinsurance after deductible | Office visit copay covers evaluation. |
| | Skilled nursing care | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | Prior authorization required. Limited to 90 days in any consecutive 12-month period. |
| | Durable medical equipment | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | Prior authorization may be required. |
| | Hospice services | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | Hospice respite care limited to 15 inpatient and 15 outpatient days per lifetime. Hospice respite care must be used in increments of not more than 5 days at a time. |
| **If your child needs dental or eye care** | Children's eye exam | No charge | 50% coinsurance after deductible | Limited to 1 visit per calendar year. Benefit ends at the end of the month when the member turns 19. |
| | Children's glasses | **Sanford Preferred or Affiliated:** 30% coinsurance after deductible | 50% coinsurance after deductible | 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 | 50% coinsurance after deductible | 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 sanfordhealthplan.com. |

## Excluded Services & Other Covered Services:

| Services Your Plan Generally Does NOT Cover (Check your policy or 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 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 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 & Grievances at 1-800-752-5863 or contact the South Dakota Division of Insurance at 605-773-3563.

**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 1-800-752-5863 (*toll-free).*
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-752-5863 (*toll-free).*
Chinese (中文): 如果需要中文的帮助， 请拨打这个号码 1-800-752-5863 (*toll-free).*
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-752-5863 (*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 plan's overall deductible** | **$1,750** |
| ■ **Specialist copayment** | **$25** |
| ■ **Hospital (facility) coinsurance** | **30%** |
| ■ **Other coinsurance** | **30%** |

**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 | $1,750 |
| Copayments | $10 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$1,820** |

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

| | |
|---|---|
| ■ **The plan's overall deductible** | **$1,750** |
| ■ **Specialist copayment** | **$25** |
| ■ **Hospital (facility) coinsurance** | **30%** |
| ■ **Other coinsurance** | **30%** |

**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** | **$5,600** |
|---|---|
| **In this example, Joe would pay:** | |
| *Cost Sharing* | |
| Deductibles | $100 |
| Copayments | $1,000 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Joe would pay is** | **$1,120** |

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

| | |
|---|---|
| ■ **The plan's overall deductible** | **$1,750** |
| ■ **Specialist copayment** | **$25** |
| ■ **Hospital (facility) coinsurance** | **30%** |
| ■ **Other coinsurance** | **30%** |

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

| **Total Example Cost** | **$2,800** |
|---|---|
| **In this example, Mia would pay:** | |
| *Cost Sharing* | |
| Deductibles | $1,750 |
| Copayments | $100 |
| Coinsurance | $0 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,850** |

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

# Non-discrimination notice

SANFORD HEALTH PLAN

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law.

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, 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, call (800) 752-5863 (TTY: 711)

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with the Section 504 Coordinator at:

Mailing Address: Section 504 Coordinator
2301 E. 60th Street, Sioux Falls, SD 57103
Telephone number: (877) 473-0911 (TTY: 711)
Fax: (605) 312-9886
Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by phone, mail, fax, or email. If you need help filing a grievance, the Section 504 Coordinator is available to help you. 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, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)

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

# Help in Other Languages

For help in any language other than English, call (800) 752-5863 (TTY: 711).

**Arabic** – خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن
(رقم هاتف الصم والبكم: 711) (800) 752-5863

**Amharic** – ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶችማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (800) 752-5863 (መስማት ለተሳናቸው:711).

**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 (800) 752-5863 (TTY: 711)。

**Cushite (Oromo)** – XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 752-5863 (TTY: 711).

**German** – ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 752-5863 (TTY: 711).

**Hmong** – LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 752-5863 (TTY: 711).

**Karen** – ဟ်သူဉ်ဟ်သး– နမ့်ကတိၤ ကညီ ကျိာ်အယိ, နမၤနှ့် ကျိာ်အတၢ်မၤစၢၤလၢတလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. ကိး (800) 752-5863 (TTY: 711).

**Korean** – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 752-5863 (TTY: 711) 번으로 전화해 주십시오.

**Laotian** – ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (800) 752-5863 (TTY: 711).

**French** – ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 752-5863 (TTY: 711).

**Russian** – ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 752-5863 (телетайп: 711).

**Spanish** – ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 752-5863 (TTY: 711).

**Tagalog** – PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 752-5863 (TTY: 711).

**Thai** – เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 752-5863 (TTY: 711).

**Vietnamese** – CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 752-5863 (TTY: 711).