

 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 <https://member.sanfordhealthplan.org/portal/> or call 1-800-752-5863 (toll-free) | TTY/TDD: 711 (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 <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 <u>deductible</u> ?	For <u>network providers</u> \$1,000 individual / \$2,000 family. For <u>out-of-network providers</u> \$2,000 individual / \$4,000 family. <u>Copays</u> do not apply to <u>deductible</u> .	Generally, you must pay all the costs from the <u>providers</u> up to the <u>deductible</u> amount before this plan begins to pay. If you have other family members on the plan, 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> .
Are there services covered before you meet your <u>deductible</u> ?	Yes. <u>Preventive care</u> services are covered before you meet your <u>deductible</u> .	This plan 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 plan covers certain <u>preventive services</u> without <u>cost sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at <a href="http://www.healthcare.gov/coverage/preventive-care-benefits">www.healthcare.gov/coverage/preventive-care-benefits</a>
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	For <u>network providers</u> \$2,000 individual / \$4,000 family. For <u>out-of-network providers</u> \$4,000 individual / \$8,000 family.	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 plan, 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.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance billing</u> charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.sanfordhealthplan.com">www.sanfordhealthplan.com</a> or call 1-800-752-5863 for a list of <u>network providers</u> .	This plan uses a <u>provider</u> network. You will pay less if you use a <u>provider</u> in the plan's network. You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your plan pays ( <u>balance billing</u> ).
Do you need a <u>referral</u> to see a <u>specialist</u> ?	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
		Network provider (You will pay the least)	Out-of-network provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$35 <u>copay</u> / visit	50% <u>coinsurance</u> after <u>deductible</u>	None
	Chiropractic visit	\$35 <u>copay</u> / visit	50% <u>coinsurance</u> after <u>deductible</u>	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> .
	<u>Specialist</u> visit	\$35 <u>copay</u> / visit	50% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care</u> / screening / Immunization	No charge	50% <u>coinsurance</u> after <u>deductible</u>	You may have to pay for services that aren't part of the <u>preventive</u> health guidelines. Ask your <u>provider</u> if the services you need are <u>preventive</u> . Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	50% <u>coinsurance</u> after <u>deductible</u>	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)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization may be required.

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 drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at <a href="https://sanfordhealthplan.com/pharmacy">sanford health plan.com /pharmacy</a>	Tier 1 Generic drugs less than \$6	\$0 <u>copay</u> / prescription	Not covered	Covers up to a 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> .  If the cost of the prescription falls under the <u>copay</u> 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	\$15 <u>copay</u> / prescription	Not covered	
	Tier 2 Preferred brand drugs	\$35 <u>copay</u> / prescription	Not covered	
	Tier 3 Non-Preferred brand drugs	\$50 <u>copay</u> / prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Certain outpatient services may require authorization (pre-approval) by the <u>plan</u> . For a list of services, see the Prior Authorization list at <a href="https://sanfordhealthplan.com">sanfordhealthplan.com</a> .
	Physician/surgeon fees	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None

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 immediate medical attention	Emergency room care	\$150 <u>copay</u> / visit	\$150 <u>copay</u> / visit	Emergency Room <u>copay</u> waived if directly admitted.
	Emergency medical transportation	30% <u>coinsurance</u> after <u>deductible</u>	30% <u>coinsurance</u> after <u>deductible</u>	None
	Urgent care	\$35 <u>copay</u> / visit	\$35 <u>copay</u> / visit	Additional services may be subject to <u>deductible</u> / <u>coinsurance</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required.
	Physician/surgeon fees	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services Office visit:	\$35 <u>copay</u> / visit	50% <u>coinsurance</u> after <u>deductible</u>	None
	Other outpatient services:	30% <u>coinsurance</u> after <u>deductible</u>		
	Inpatient services	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required.
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u> after <u>deductible</u>	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	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	Childbirth/delivery facility services	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	

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	<u>Home health care</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required. Limited to 120 visits per calendar year.
	<u>Rehabilitation services</u> Office visit: \$35 <u>copay</u> / visit Other outpatient services: 30% <u>coinsurance</u> after <u>deductible</u>		50% <u>coinsurance</u> after <u>deductible</u>	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> Office visit: \$35 <u>copay</u> / visit Other outpatient services: 30% <u>coinsurance</u> after <u>deductible</u>		50% <u>coinsurance</u> after <u>deductible</u>	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>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required. Limited to 120 days in any consecutive 12-month period.
	<u>Durable medical equipment</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization may be required.
	<u>Hospice services</u>	30% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
If your child needs dental or eye care	Children's eye exam	Covered	Covered	Limited to one routine exam annually.
	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.)

- |                       |  |                        |
|-----------------------|--|------------------------|
| • Cosmetic Surgery    | • Infertility treatment                              | • Long-term care       |
| • Dental care (Adult) | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |

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

- |                     |                        |   |
|---------------------|------------------------|---|
| • Acupuncture       | • Hearing Aids         | • Routine eye care (Adult)                |
| • Bariatric Surgery | • Private Duty Nursing | • Telehealth/e-visit/video visit services |
| • Chiropractic Care | • Routine foot care    |   |

**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: Minnesota Department of Health at 1-651-201-5100/1-800-657-3916, or the 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 MNsure. For more information about MNsure, visit <https://www.mnsure.org> or call 1-855-366-7873.

**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 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 Minnesota Department of Health at 1-651-201-5100/1-800-657-3916.

**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 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 1-800-752-5863 (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, kwijigo holne' 1-800-752-5863 (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 \$1,000
- Specialist copayment \$35
- 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
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In this example, Peg would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$0
Coinsurance	\$1,000
What isn't covered	
Limits Or Exclusions	\$60
The Total Peg Would Pay Is	\$2,060

### Managing Joe's type 2 Diabetes

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

- The plan's overall deductible \$1,000
- Specialist copayment \$35
- 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
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In this example, Joe would pay:

Cost Sharing	
Deductibles	\$100
Copayments	\$1,200
Coinsurance	\$0
What isn't covered	
Limits Or Exclusions	\$20
The Total Joe Would Pay Is	\$1,320

### Mia's Simple Fracture

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

- The plan's overall deductible \$1,000
- Specialist copayment \$35
- Hospital (facility) coinsurance 30%
- Other coinsurance 30%

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	\$2,800
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$1,000
Copayments	\$300
Coinsurance	\$300
What isn't covered	
Limits Or Exclusions	\$0
The Total Mia Would Pay Is	\$1,600

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

# Non-discrimination notice



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](mailto: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 ድርጅቶቻችንማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፡ በነፃ ሊያግዝዎት ተዘጋጅተዋል፡ 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** – ဟ်သုဉ်ဟ်သး- နမုာ်ကတိၤ ကညိ ကျိာ်အယိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘျုးတၢ်စ့ၤ နီတမံၤဘျုးသ့န့ၢ်လီၤ. 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, ການບໍລິການຊ່ວຍເຫຼືອດ້ານ ພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ (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: ถ้าคุณพูดภาษาไทยคุณสามารถใช้ บริการช่วยเหลือทางภาษาไทยได้ ฟรี 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).