



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, <https://member.sanfordhealthplan.org/portal> or by calling 1-877-701-0792 | 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 <http://www.healthcare.gov/sbc-glossary> or call 1-877-701-0792 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u>?	For <u>Network Providers</u> \$0 Individual / \$0 Family No out-of-network coverage Doesn't apply to preventive care or prescription drugs. <u>Copays</u> and <u>coinsurance</u> do not apply to the <u>deductible</u> .	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> .
Are there services covered before you meet your <u>deductible</u>?	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 https://www.healthcare.gov/coverage/preventive-care-benefits/ .
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 annual maximum for this plan?	For <u>Network Providers</u> \$3,000 Individual / \$6,000 Family No out-of-network coverage.	The <u>out-of-pocket</u> limit 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</u> limits until the overall family <u>out-of-pocket</u> limit has been met.
What is not included in the <u>out-of-pocket</u> maximum?	<u>Premiums</u> , <u>balance-billing</u> charges, and health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket</u> limit.
Do you need a <u>referral</u> to see a <u>specialist</u>?	No.	You can see the <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	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> / visit	Not covered	None.
	Chiropractic visit	\$50 <u>copay</u> / visit	Not covered	Chiropractor visits include manual manipulation of the spine and extremities and therapy and diagnostic services. Limited to 30 visits, additional visits if medically necessary with PA.
	<u>Specialist</u> visit	\$50 <u>copay</u> / visit	Not covered	None.
	<u>Preventive care/screening/immunization</u>	No charge	No charge	You may have to pay for services that are not <u>preventive</u> . 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)	20% <u>coinsurance</u>	Not covered	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u>	Not covered	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at sanfordhealthplan.com/pharmacy	Tier 1 — Generic drugs	\$0 <u>copay</u> for 1-90 day supply	Not Covered	Covers 30-day supply up to 90-day supply by either retail or mail order pharmacy.
	Tier 2 — Preferred (<u>Formulary</u>) brand drugs	\$20 <u>copay</u> for 1-30 day supply \$40 <u>copay</u> for 31-90 day supply	Not covered	Brand name drugs with generic equivalents or biosimilar alternatives require additional cost share.
	Tier 3 — Non-preferred (Non- <u>Formulary</u>) brand drugs	\$50 <u>copay</u> for 1-30 day supply \$100 <u>copay</u> for 31-90 day supply	Not covered	Substance abuse medications are covered at \$0 <u>copay</u> Refer to your <u>Formulary</u> to determine which benefit applies to your medication.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-Of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$250 <u>copay</u> , then 20% <u>coinsurance</u>	Not covered	Prior authorization <u>may be</u> required
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	\$200 <u>copay</u> / visit, then 20% <u>coinsurance</u>	\$200 <u>copay</u> / visit, then 20% <u>coinsurance</u>	Emergency room <u>copay</u> waived if directly admitted.
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u>	20% <u>coinsurance</u>	
	<u>Urgent care</u>	\$50 <u>copay</u>	\$50 <u>copay</u>	
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> , then 20% <u>coinsurance</u>	Not covered	Not covered
	Physician/surgeon fees	20% <u>coinsurance</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	Not covered	Prior authorization for all SUD must be obtained through MHA Recovery at (701) 421-8869. Intensive Outpatient Program for SUD and Partial Hospitalization Program for SUD require Prior authorization
	Inpatient services	No Charge with Prior Authorization	Not covered	Prior authorization for Mental and Behavioral services obtained through Sanford Health Plan UM. Prior authorization for all SUD must be obtained through MHA Recovery at (701) 421-8869.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-Of-Network Provider	
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> / <u>coinsurance</u> may apply. Maternity care may include tests and services (i.e. ultrasound).
	Childbirth/delivery professional services	20% <u>coinsurance</u>	Not covered	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	Not covered	
If you need help recovering or have other special health needs	Home Health care	20% <u>coinsurance</u>	Not covered	Limited to 40 visits, additional visits if medically necessary with PA
	Physical Therapy/Occupational Therapy	20% <u>coinsurance</u>	Not covered	Limited to 30 visits, additional visits if medically necessary with PA
	Speech Therapy	20% <u>coinsurance</u>	Not covered	Limited to 45 visits, additional visits if medically necessary with PA
	<u>Skilled nursing care</u>	\$250 <u>copay</u> / visit, then 20% <u>coinsurance</u>	Not covered	Prior authorization required. Limited to 70 visits per calendar year.
	<u>Durable medical equipment</u>	20% <u>coinsurance</u>	Not covered	Prior authorization required
	<u>Hospice services</u>	\$250 <u>copay</u> / visit, then 20% <u>coinsurance</u>	Not covered	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	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.)

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|--------------------|-----------------------------------|------------------------|
| • Cosmetic surgery | • Pediatric dental & vision care | • Routine foot care |
| • Long-term care | • Routine dental services (adult) | • Weight loss programs |
| | • Routine eye care (adult) | |

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

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|----------------|---|-----------------------|
| • Acupuncture | • Infertility diagnostic services | • Travel vaccines |
| • Hearing aids | • Orthotic Devices due to complications of Diabetes | • Weight loss surgery |

Your Rights to Continue Coverage: 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. 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 a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sanford Health Plan at 1-800-752-5863.

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 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 pre-natal care and a hospital delivery)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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
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In this example, Peg would pay:

Managing Joe's type 2 Diabetes

(a year of routine care of a well-controlled

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	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	\$5,600
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In this example, Joe would pay:

Mia's Simple Fracture

(emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist copayment</u>	\$50
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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
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In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$0
Coinsurance	\$2,528
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$2,588

Cost Sharing	
Deductibles	\$0
Copayments	\$500
Coinsurance	\$1020
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,540

Cost Sharing	
Deductibles	\$0
Copayments	\$600
Coinsurance	\$440
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$1,040

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

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
(800) 752-5863 (رقم هاتف الصم والبكم: 711).

Amharic – ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጅተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ (800) 752-5863 (ማስማት 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 – ဟံသာဝတီသား- နမူကတိက ကညီ ကျိာ်အသိ, နမူနာ ကျိာ်အတိမၤစၢၤလၢ တလၢာ်ဘျုးလၢာ်စ့ၤ နီတမံၤဘျုးသ့န့ၣ်လီၤ. 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, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. 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: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาไทย 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).