SANFORD HEALTH PLAN

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

Three Affiliated Tribes (Substance Use Disorder and Transplant Benefit Plan) – self-funded

Coverage Period: 07/01/2026 – 12/31/2026

Coverage for: Individual | **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, **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 deductible?	For Network Providers **$0** Individual / **$0** Family No out-of-network coverage Doesn't apply to prescription drugs. Copays and coinsurance do not apply to the 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. Primary Care Services related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant 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 primary care services without cost sharing and before you meet your deductible.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the annual maximum for this plan?	For Network Providers **$3,000** Individual / **$6,000** Family No out-of-network coverage.	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 maximum?	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.
Do you need a referral to see a specialist?	No.	You can see the 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	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary Care Visits related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	$20 copay / visit	Not covered	None
	Specialist Visits related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	$50 copay / visit	Not covered	None
If you have a test	Diagnostic Tests (x-ray, blood work) related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	20% coinsurance	Not covered	Prior authorization required
	Imaging (CT/PET scans, MRIs) related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	20% coinsurance	Not covered	Prior authorization required
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at sanfordhealthplan.com/pharmacy	Tier 1 — Generic Drugs related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	$0 copay for 1-90 day supply	Not covered	Covers 30-day supply up to 90-day supply by either retail or mail order pharmacy. Brand name drugs with generic equivalents or biosimilar alternatives require additional cost share. Substance abuse medications are covered at $0 copay Refer to your Formulary to determine which benefit applies to your medication.
	Tier 2 — Preferred (Formulary) Brand Drugs related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	$20 copay for 1-30 day supply $40 copay for 31-90 day supply	Not covered	
	Tier 3 — Non-Preferred (Non-Formulary) Brand Drugs related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	$50 copay for 1-30 day supply $100 copay for 31-90 day supply	Not covered	

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) related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	$250 copay, then 20% coinsurance	Not covered	Certain outpatient services may require Prior Authorization.
	Physician/Surgeon Fees related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	20% coinsurance	Not covered	None
If you need immediate medical attention	Emergency Room Care	$200 copay / visit, then 20% coinsurance	Not covered	Emergency room copay waived if directly admitted.
	Emergency Medical Transportation	20% coinsurance	Not covered	
	Urgent Care	$50 copay	Not covered	
If you have a hospital stay	Facility Fee (e.g., hospital room) related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	$250 copay, then 20% coinsurance	Not covered	Prior authorization required for all SUD Services through MHA Recovery at (701) 421-8869.
	Physician/Surgeon Fees related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	20% coinsurance	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-Of-Network Provider	
If you need mental health, behavioral health, or substance abuse services	Outpatient Services related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	No Charge	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. Intensive Outpatient Program for SUD and Partial Hospitalization Program for SUD require Prior authorization.
	Inpatient Services related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant 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.
If you need help recovering or have otherspecialhealth needs	Home Health Care related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	20% coinsurance	Not covered	Prior authorization required forall SUDServices through MHA Recovery at (701) 421-8869.
	Rehabilitation Services related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	20% coinsurance	Not covered	Limited to 30 visits per calendar year.
	Habilitation Services related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	20% coinsurance	Not covered	Limited to 30 visits per calendar year.
	Skilled Nursing Care related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	$250 copay / visit, then 20% coinsurance	Not covered	Prior authorization required forall SUDServices through MHA Recovery at (701) 421-8869.
	Durable Medical Equipment related to the treatment of Mental and Behavioral Health, Substance Use Disorder and Transplant services	20% coinsurance	Not covered	Prior authorization required forall SUDServices through MHA Recovery at (701) 421-8869.

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.)		
• Artificial organs • Take-home drugs	• Transportation	• Transplants and transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Long-Term residential facilities are covered with certification	• Residential Care is covered if Medically Necessary and with use of treatment centers that are preapproved	• Some Transplant Services may require Tribal Council Approval prior to treatment

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? **No.**
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? **No.**
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).*

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 (800) 752-5863 (رقم هاتف الصم والبكم: 711). ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن.

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– နမ့ၢ်ကတိၤ ကညီ ကျိာ်အဃိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤစၢၤလၢတလၢာ်ဘူဉ်လၢာ်စ့ၢ 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, ການບໍລິການຊ່ວຍເຫຼ ືອດ້ານ ພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີ ພ້ອມໃຫ້ທ່ານ. 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: ถ าคุณพูดภาษาไทยคุณสามารถใช บริ การช วยเหลื อทางภาษาได ี 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).