SANFORD HEALTH PLAN

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

MHA Nation | North Dakota

Coverage Period: 1/01/2021-12/31/2021

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, **https://member.sanfordhealthplan.org/portal/** or by calling **1-800-752-5863** *(toll free)* | TTY/TDD: **1-877-652-1844** *(toll-free)*. For general definitions of common terms, such as **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?	**$0** Single **$0** Single + Dependents **$0** Family 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. 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?	Yes.	You must meet a $500 deductible for infertility services.
What is the out-of-pocket limit for this plan?	**$2,500** Single **$3,750** Single + Dependents **$5,000** 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, 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.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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.

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	30% coinsurance	70% coinsurance	None
	Chiropractic visit	30% coinsurance	70% coinsurance	None
	Specialist visit	30% coinsurance	70% coinsurance	None
	Preventive care/ immunization	No charge	Not covered	You may have to pay for services that aren't part of the preventive 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)	30% coinsurance	70% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	70% coinsurance	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 drugs to treat your illness or condition More information about prescription drug coverage is available at sanfordhealthplan.com/pharmacy	Tier 1 Generic drugs less than $6 Generic drugs greater or equal to $6	$0 copay / prescription $15 copay / prescription + 30% coinsurance	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 deductible or out-of-pocket limit. 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.
	Tier 2 Formulary Preferred brand-name drugs	$15 copay / prescription + 30% coinsurance	Not covered	
	Tier 3 Non-formulary Preferred brand-name drugs	$15 copay / prescription + 50% coinsurance	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	70% coinsurance	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	30% coinsurance	70% coinsurance	None
If you need immediate medical attention	Emergency room care	30% coinsurance	30% coinsurance	None
	Emergency medical transportation	30% coinsurance	30% coinsurance	None
	Urgent care	30% coinsurance	30% coinsurance	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 have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	70% coinsurance	Prior authorization required.
	Physician/surgeon fees	30% coinsurance	70% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% coinsurance	70% coinsurance	For outpatient services, the first 5 visits of any calendar year will be 100% (no charge). For full details please refer to your policy.
	Inpatient services	20% coinsurance	70% coinsurance	
If you are pregnant	Office visits	No Charge	70% coinsurance	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	30% coinsurance	70% coinsurance	
	Childbirth/delivery facility services	30% coinsurance	70% coinsurance	
If you need help recovering or have other special health needs	Home health care	30% coinsurance	70% coinsurance	Prior authorization may be required.
	Rehabilitation services	30% coinsurance	70% coinsurance	Limited to 90 visits per calendar year.
	Habilitation services	30% coinsurance	70% coinsurance	Limited to 90 visits per calendar year.
	Skilled nursing care	30% coinsurance	70% coinsurance	None
	Durable medical equipment	30% coinsurance	70% coinsurance	Prior authorization may be required.
	Hospice services	30% coinsurance	70% coinsurance	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 document for more information and a list of any other excluded services.)		
• Acupuncture	• Long-term care	• Routine eye care (Adult)
• Cosmetic surgery	• Non-emergency care when traveling outside the U.S.	• Weight loss programs (unless prescribed by a physician to accomplish treatment goals)
• Dental care		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your document.)		
• Bariatric Surgery	• Infertility treatment up to $20,000 lifetime maximum	• Private duty nursing
• Chiropractic Care	• Hearing Aids (refer to your Policy for more information)	• Routine foot care (for diabetics only) • Telehealth / e-visits / video visits

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: North Dakota Insurance Department 1-800-247-0560. 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 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 Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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? 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 1-800-892-0675 (*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, kwiijigo 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. *The Specialist copayment assumes you are using a Sanford Provider.

Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**30%**
■ **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	$0
Copayments	$10
Coinsurance	$1,800
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$1,870**

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

■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**30%**
■ **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*	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

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

■ **The plan's overall deductible**	**$0**
■ **Specialist copayment**	**30%**
■ **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*	$0
Copayments	$800
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$800**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Sanford Wellness at 1-877-305-5463.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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