




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://www.sanfordhealthplan.com/-/media/plan-documents/2020/HP-2507.pdf> 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 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> ?	Tier 1 TRUE <u>network providers</u> \$3,000 individual / \$6,000 family. Tier 2 PLUS <u>network providers</u> \$6,000 individual / \$12,000 family. For <u>out-of-network providers</u> \$9,000 individual / \$18,000 family.	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 <u>out-of-pocket limit</u> for this <u>plan</u> ?	Tier 1 TRUE <u>network providers</u> \$6,000 individual / \$12,000 family. Tier 2 PLUS <u>network providers</u> \$6,900 individual / \$13,200 family. For <u>out-of-network providers</u> \$18,000 individual / \$36,000 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 <u>plan</u> , 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 <u>plan</u> 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 www.sanfordhealthplan.com or call 1-800-752-5863 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay the least if you use a <u>provider</u> in Tier 1 TRUE Network. You will pay more if you use a <u>provider</u> in Tier 2 PLUS network. You will pay the most if you use a TIER 3 <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 <u>plan</u> pays (<u>balance billing</u>). Be aware your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
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
		Tier 1 TRUE Network Provider (You will pay the least)	Tier 2 PLUS Network provider (You will pay more)	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	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Chiropractic visit	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/immunization</u>	No charge	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 these services you need are preventive. 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> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sanfordhealthplan.com/memberlogin	Preventive drugs	\$5 <u>copay</u> / prescription. <u>Copay</u> does not apply to <u>deductible</u> .	\$5 <u>copay</u> / prescription. <u>Copay</u> does not apply to <u>deductible</u> .	Not covered	Covers up to a 30-day supply.
	Generic drugs (Tier 1)	20% <u>coinsurance</u> / prescription after <u>deductible</u>	20% <u>coinsurance</u> / prescription after <u>deductible</u>	Not covered	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</u> limit.
	Preferred brand drugs (Tier 2)	20% <u>coinsurance</u> / prescription after <u>deductible</u>	20% <u>coinsurance</u> / prescription after <u>deductible</u>	Not covered	Refer to your <u>Formulary</u> to determine which benefit applies to your medication.
	Non-preferred brand drugs (Tier 3)	20% <u>coinsurance</u> / prescription after <u>deductible</u>	20% <u>coinsurance</u> / prescription after <u>deductible</u>	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Tier 1 TRUE Network Provider (You will pay the least)	Tier 2 PLUS Network provider (You will pay more)	Out-of-network provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after <u>deductible</u>	40% <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 Plan. For a list of services, see the Prior Authorization list at sanfordhealthplan.com.
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required.
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	40% <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	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	None
	Inpatient services	20% <u>coinsurance</u> after <u>deductible</u>	40% <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	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	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u> after <u>deductible</u>	40% <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
		Tier 1 TRUE Network Provider (You will pay the least)	Tier 2 PLUS Network provider (You will pay more)	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>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required. Limited to 120 days per calendar year.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Limited to 30 visits per calendar year.
	<u>Habilitation services</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Limited to 30 visits per calendar year.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <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>	20% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Prior authorization may be required.
	<u>Hospice services</u>	20% <u>coinsurance</u> after <u>deductible</u>	40% <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	Not covered	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	Not covered	None
	Children's dental check-up	Not covered	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 | • Non-emergency care when traveling outside the U.S. |
| • Dental care (Adult) | • Long-term care | • 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 | • Routine foot care (for diabetics only) |
| • Chiropractic Care | | • 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: Minnesota Department of Health at 1-651-201-5100/1-800-657-3916. 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. Minnesota Department of Health at 1-651-201-5100/1-800-657-3916.

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 1-800-892-0675 (*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, kwijijigo holne' 1-800-892-0675 (*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 **\$3,000**
- Specialist copayment **Coinsurance**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **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
In this example, Peg would pay:	
<i>Cost Sharing</i>	
Deductibles	\$3,000
Copayments	\$0
Coinsurance	\$1,200
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$4,260

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

- The plan's overall deductible **\$3,000**
- Specialist copayment **Coinsurance**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **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	\$7,400
In this example, Joe would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$3,000
Copayments	\$0
Coinsurance	\$800
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$3,860

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

- The plan's overall deductible **\$3,000**
- Specialist copayment **Coinsurance**
- Hospital (facility) coinsurance **20%**
- Other coinsurance **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	\$1,900
In this example, Mia would pay:	
<i>Cost Sharing</i>	
Deductibles*	\$1,800
Copayments	\$0
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,800

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.

Non-discrimination notice

Sanford Health Plan does not discriminate against any future, current, or past Member on the basis of race; ethnicity; color; national origin; disability; sex; gender; sexual orientation; gender identity; religion; spiritual beliefs; medical condition, including a current or past history of mental health and substance use disorders; sources of payment for care; or age, in its coverage, treatment, or benefit decisions. 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, or 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, contact our Civil Rights Coordinator.

If you believe that Sanford Health Plan has failed to provide these services or discriminated in any way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Director of Customer Service, 300 Cherapa Place #201, Sioux Falls, SD 57103, (800) 752-5863, TTY/TDD (877) 652-1844, fax (605) 328-6812, memberservices@sanfordhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights 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, DC 20201, (800) 368-1019, (800) 537-7697 (TDD).

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

Free help in other languages

For help in a language other than English, please call us toll-free at (800) 892-0675. Both oral and written translation services are available for free in at least 150 languages. If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-892-0675 (TTY: 1-877-652-1844).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-892-0675 (TTY: 1-877-652-1844).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-892-0675 (TTY: 1-877-652-1844).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-892-0675 (TTY: 1-877-652-1844).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-892-0675 (TTY: 1-877-652-1844).

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 1-800-892-0675 (TTY: 1-877-652-1844)。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-892-0675 (TTY: 1-877-652-1844).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-892-0675 (телетайп: 1-877-652-1844)

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-892-0675 (TTY: 1-877-652-1844).

Arabic: خدمات فإن، اللغة اذكر تتحدث كنت إذا: ملحوظة 1-877-652-1844 (رقم) والبكم الصم هاتف 1-800-892-0675 برقم اتصل. بالمجان لك تتوافر اللغوية المساعدة

Karen:

ဟံသုဉ်ဟံသး- နမုာ်ကတိာ် ကညီ ကျိဉ်အထိ, နမုာ်န့ၢ် ကျိဉ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘျုးလၢာ်စ့ၤ နီတၢ်စၢၤဘျုးသုဉ်လၢ. ကိ: 1-800-892-0675 (TTY: 1-877-652-1844).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚክተለው ቁጥር ይደውሉ 1-800-892-0675 (መስማት ለተሳናቸው: 1-877-652-1844)።

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-892-0675 (TTY: 1-877-652-1844). 번으로 전화해 주십시오.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-892-0675 (ATS : 1-877-652-1844).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-892-0675 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-877-652-1844).

Cambodian, Mon-Khmer:

សម្រាប់: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូ ទូរស័ព្ទ 1-800-892-0675 (TTY: 1-877-652-1844)។

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