




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. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, visit sanfordhealthplan.com 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 at healthcare.gov.

Notice to buyer: This policy may not cover all of the costs associated with short-term care incurred by the buyer during the period of coverage. The buyer is advised to review carefully all policy limitations. This is a short-term care policy that offers benefits for less than twelve (12) months. This is not a long-term care policy or policy compliant to meet the coverage requirements of the Affordable Care Act.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For <u>network providers</u> \$2,500 individual / \$7,500 family. For <u>out-of-network providers</u> \$7,500 individual / \$22,500 family. Copays do not apply to 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. Limited 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.
Are there other deductibles for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the out-of-pocket limit for this plan?	For <u>network providers</u> \$5,000 individual / \$15,000 family. For <u>out-of-network providers</u> \$15,000 individual / \$45,000 family.	The <u>out-of-pocket limit</u> is the most you could pay in a coverage period 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 out-of-pocket limit?	<u>Premium</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 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 <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a provider in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the <u>provider's charge</u> and what your <u>plan</u> pays (balance billing). 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 provider before you get services.
Do you need a referral to see a specialist?	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 provider's office or clinic	Primary care visit to treat an injury or illness	\$50 copay for one visit, then 20% coinsurance after deductible	50% coinsurance after deductible	Copay limited to 1 visit per covered person per 3-month period.
	Specialist visit	20% coinsurance after deductible	50% coinsurance after deductible	None.
	Preventive care/screening/immunization	Not covered	Not covered	You may have to pay for services that aren't part of the preventive health 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)	20% coinsurance after deductible	50% coinsurance after deductible	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance after deductible	50% coinsurance after deductible	None
If you need drugs to treat your illness or condition	Outpatient Prescription drugs (received at pharmacy or as a take home drug)	Not covered	Not covered	A discount Plan for prescription drugs is included. Simply show your Sanford Health Plan ID card at the pharmacy.
	Prescription drugs received while confined in a hospital or surgery center	20% coinsurance after deductible	50% coinsurance after deductible	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance after deductible	50% coinsurance after deductible	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% coinsurance after deductible	50% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	20% coinsurance after deductible	20% coinsurance after deductible	None
	Emergency medical	20% coinsurance after	20% coinsurance after	None

	transportation	<u>deductible</u>	<u>deductible</u>	
	Urgent care	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	Additional services may be subject to - <u>deductible</u> / <u>coinsurance</u> .
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <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>	50% <u>coinsurance</u> after <u>deductible</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Not covered	Not covered	None
	Inpatient services	Not covered	Not covered	None
If you are pregnant	Office visits	Not covered	Not covered	Treatment of medically necessary services due to illness or injury is covered for the mother.
	Childbirth/delivery professional services	Not covered	Not covered	
	Childbirth/delivery facility services	Not covered	Not covered	
If you need help recovering or have other special health needs	Home health care	Not covered	Not covered	None
	Rehabilitation services	Not covered	Not covered	Exceptions for treatment provided for diagnosis and Rehabilitative treatment necessary to recover from a covered Injury or Sickness that occurred while covered under the policy.
	Habilitation services	Not covered	Not covered	None
	Skilled nursing care	Not covered	Not covered	None
	Durable medical equipment	Not covered	Not covered	Exceptions for oxygen, crutches, and certain equipment rentals.
	Hospice services	Not covered	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 .)		
<ul style="list-style-type: none">• Acupuncture• Bariatric Surgery• Chiropractic Care• Cosmetic surgery• Dental care (Adult)	<ul style="list-style-type: none">• Hearing aids• Infertility treatment• Long-term care• Non-emergency care when traveling outside the U.S.• Outpatient Prescription Drugs• Pre-existing conditions	<ul style="list-style-type: none">• Pre-Natal/Maternity Care• Preventive Care• Private-duty nursing• Routine eye care (Adult)• Routine foot care (for diabetics only)• Weight loss programs
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none">• 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: South Dakota Department of Labor at 1-605-773-3101. 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? 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 the 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 1-800-892-0675 (*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, kwijigo holne' 1-800-892-0675 (*toll-free*).

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 ကျိဉ်အယိ, နမုာ်န့ၢ် ကျိဉ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘျုးလၢာ်စ့ၤ နီတၢ်စၢၤဘျုးသုန့ၢ်လီၤ. 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 ដោយមិនគិតល្អ្មល គឺអាចមានសំរាប់អ្នក។ ចូ ទូរស័ព្ទ 1-800-892-0675 (TTY: 1-877-652-1844)។

Help understanding this document is free

If you would like this policy in another format (for example, a larger font size of a file for use with assistive technology, like a screen reader), please call us at:
(800) 752-5863 (toll-free) | TTY/TDD: (877) 652-1844