



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, sanfordhealthplan.com/sbcfinder 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>? | For <u>network providers</u> \$1,750 individual / \$3,500 family. For out-of-network <u>providers</u> \$3,500 individual / \$7,000 family. Copays do not apply to <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 <u>out-of-pocket limit</u> for this <u>plan</u>? | For <u>network providers</u> \$6,750 individual / \$13,500 family. For out-of-network <u>providers</u> \$13,500 individual / \$27,000 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 (unless balanced billing is prohibited), 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 <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 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</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 provider 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.

Sanford Preferred Providers: Sanford Health Practitioners and/or Facilities. With Sanford Preferred Providers, you will pay Tier-1 In-Network Benefits.

Affiliated Providers: All other In-Network Practitioners and/or facilities. With Affiliated Providers, you will pay Tier-2 In-Network Benefits.

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|--|---|------------------------------------|--|--|
| | | Network provider (You will pay the least) | Indian Health Care Provider (IHCP) | 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 | Sanford Preferred: \$10 <u>copay</u> / office visit Affiliated: \$30 <u>copay</u> / office visit | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | Chiropractic visit | Sanford Preferred: \$10 <u>copay</u> / office visit Affiliated: \$10 <u>copay</u> / office visit | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | Office visit <u>copay</u> applies to the office visit charge and manual manipulation only. All other eligible modalities and therapies are subject to <u>deductible</u> / <u>coinsurance</u> . Limited to 20 visits per calendar year. |
| | <u>Specialist</u> visit | Sanford Preferred: \$35 <u>copay</u> / office visit Affiliated: \$55 <u>copay</u> / office visit | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | <u>Preventive care/screening/immunization</u> | No charge | No charge | 45% <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) | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | Imaging (CT/PET scans, MRIs) | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|--|---|---------------------------------------|--|--|
| | | Network provider (You will pay the least) | Indian Health Care Provider (IHCP) | 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 | Generic drugs less than \$6 | \$0 <u>copay</u> / prescription | No charge | Not covered | Covers up to a 30-day supply. Generic cost is based on total drug cost per 30-day supply. 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 limit</u> . There are no limitations or restrictions for use of manufacturer coupons if used in conjunction with our current benefit offering. 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. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | Generic drugs greater or equal to \$6 | \$20 <u>copay</u> / prescription | No charge | Not covered | |
| | Preferred brand drugs | \$50 <u>copay</u> / prescription | No charge | Not covered | |
| | Non-preferred brand drugs | \$125 <u>copay</u> / prescription | No charge | Not covered | |
| | <u>Specialty drugs</u> | 35% <u>coinsurance</u> after <u>deductible</u> | No charge | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <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 . <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | Physician/surgeon fees | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| If you need immediate medical attention | <u>Emergency room care</u> | 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 35% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | <u>Emergency medical transportation</u> | 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 35% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | <u>Urgent care</u> | \$20 <u>copay</u> / office visit | No charge | \$20 <u>copay</u> / office visit | Additional services may be subject to <u>deductible</u> / <u>coinsurance</u> . <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---------------------------------------|--|---|
| | | Network provider (You will pay the least) | Indian Health Care Provider (IHCP) | Out-of-network provider (You will pay the most) | |
| If you have a hospital stay | Facility fee (e.g., hospital room) | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | Prior authorization required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | Physician/surgeon fees | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | Sanford Preferred: \$10 <u>copay</u> / office visit and 35% <u>coinsurance</u> for other outpatient services after <u>deductible</u> Affiliated: \$10 <u>copay</u> / office visit and 35% <u>coinsurance</u> for other outpatient services after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | Inpatient services | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| If you are pregnant | Office visits | No charge | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> 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). <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | Childbirth/delivery professional services | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | |
| | Childbirth/delivery facility services | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------------|---|---------------------------------------|--|---|
| | | Network provider (You will pay the least) | Indian Health Care Provider (IHCP) | 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> | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> | Prior authorization required. Limited to 40 visits per calendar year. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | <u>Rehabilitation services</u> | Sanford Preferred: \$10 <u>copay</u> / office visit and 35% <u>coinsurance</u> for other outpatient services after <u>deductible</u> Affiliated: \$10 <u>copay</u> / office visit and 35% <u>coinsurance</u> for other outpatient services after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | Office visit <u>copay</u> covers evaluation. Therapies are subject to <u>deductible</u> / <u>coinsurance</u> . Limited to 30 visits per calendar year. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | <u>Habilitation services</u> | Sanford Preferred: \$10 <u>copay</u> / office visit and 35% <u>coinsurance</u> for other outpatient services after <u>deductible</u> Affiliated: \$10 <u>copay</u> / office visit and 35% <u>coinsurance</u> for other outpatient services after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | Office visit <u>copay</u> covers evaluation. Therapies are subject to <u>deductible</u> / <u>coinsurance</u> . Limited to 30 visits per calendar year. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | <u>Skilled nursing care</u> | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | Prior authorization required. Limited to 30 days in any consecutive 12-month period. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | <u>Durable medical equipment</u> | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | Prior authorization may be required. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | <u>Hospice services</u> | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |

| Common Medical Event | Services You May Need | What You Will Pay | | | Limitations, Exceptions, & Other Important Information |
|--|----------------------------|---|---------------------------------------|--|--|
| | | Network provider (You will pay the least) | Indian Health Care Provider (IHCP) | Out-of-network provider (You will pay the most) | |
| If your child needs dental or eye care | Children's eye exam | No charge | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | Limited to 1 visit per calendar year. Benefit ends at the end of the month when then member turns 19. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |
| | Children's glasses | Sanford Preferred: 35% <u>coinsurance</u> after <u>deductible</u> Affiliated: 35% <u>coinsurance</u> after <u>deductible</u> | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | Limited to 1 frame every other year. Lenses or contact lenses limited to 1 item annually. Benefit ends at the end of the month when the member turns 19. |
| | Children's dental check-up | No charge | No charge | 45% <u>coinsurance</u> after <u>deductible</u> | Limited to 2 routine check-up visits per calendar year.. Preventive, emergency, and routine coverage available for members up to age 19. See your plan document for eligible services. Certain dental services may require authorization (pre-approval) by the plan. For a list of services, see the Prior Authorization list at sanfordhealthplan.com. <u>Cost sharing</u> waived at non-IHCP with IHCP <u>referral</u> . If an <u>out-of-network provider</u> charges more than the <u>allowed amount</u> , you may have to pay the difference (<u>balance billing</u>). |

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.)

- | | | |
|-----------------------|-------------------------|--|
| • Acupuncture | • Infertility treatment | • Non-emergency care when traveling outside the U.S. |
| • Cosmetic surgery | • Long-term care | • Routine eye care (Adult) |
| • Dental care (Adult) | | • Weight loss programs |

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

- | | | |
|---------------------|--|--|
| • Bariatric Surgery | • Hearing aids (except for gradual deterioration of hearing that occurs with aging and/or other lifestyle factors) | • Private-duty nursing |
| • Chiropractic Care | | • Routine foot care (for diabetics only) |

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 at 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 on how 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, kwijigo 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 **\$1,750**
- Specialist copayment **\$35**
- Hospital (facility) coinsurance **35%**
- Other coinsurance **35%**

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 | \$1,750 |
| Copayments | \$10 |
| Coinsurance | \$2,300 |

| <i>What isn't covered</i> | |
|---------------------------|------|
| Limits or exclusions | \$60 |

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$4,120 |
|-----------------------------------|----------------|

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

- The plan's overall deductible **\$1,750**
- Specialist copayment **\$35**
- Hospital (facility) coinsurance **35%**
- Other coinsurance **35%**

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:

| <i>Cost Sharing</i> | |
|---------------------|---------|
| Deductibles | \$100 |
| Copayments | \$1,300 |
| Coinsurance | \$0 |

| <i>What isn't covered</i> | |
|---------------------------|------|
| Limits or exclusions | \$20 |

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$1,420 |
|-----------------------------------|----------------|

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

- The plan's overall deductible **\$1,750**
- Specialist copayment **\$35**
- Hospital (facility) coinsurance **35%**
- Other coinsurance **35%**

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:

| <i>Cost Sharing</i> | |
|---------------------|---------|
| Deductibles | \$1,750 |
| Copayments | \$100 |
| Coinsurance | \$100 |

| <i>What isn't covered</i> | |
|---------------------------|-----|
| Limits or exclusions | \$0 |

| | |
|-----------------------------------|----------------|
| The total Mia would pay is | \$1,950 |
|-----------------------------------|----------------|

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 Sanford Health Plan at (800) 752-5863 | TTY: 711.

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 the Civil Rights Coordinator at 300 Cherapa Place #201, Sioux Falls, SD 57103, call (800) 325-9402 | TTY: 711, fax (605) 328-6812, or e-mail compliancehotline@sanfordhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the US 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: US Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, TTY/TDD (800) 537-7697. Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>

Free help in other languages

For help in any language other than English, please call **1-800-752-5863** | TTY: 711.

If you have any questions, for example, about your benefits, a document, or how Sanford Health Plan pays for your care, please call us.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Sanford Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-927-2969.

Hmong: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Sanford Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-923-3519.

Cushite: Isin yookan namni biraa isin deeggartan Sanford Health Plan irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-927-2968 tiin bilbilaa.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Sanford Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-927-2973.

Chinese (Mandarin): 如果您, 或您正在幫助的人, 有關於 Sanford Health Plan 方面的問題, 您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話, 請致電 1-844-923-3524。

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Sanford Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-923-3517 an.

