### Important Questions

| What is the overall deductible? | For network providers **$3,500** individual / **$7,000** family. No out-of-network coverage. 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. 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/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| Are there other deductibles for specific services? | No. | You don't have to meet deductibles for specific services. |
| What is the out-of-pocket limit for this plan? | For network providers **$9,100** individual / **$18,200** 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 limit? | Premiums, balance-billing charges (unless balanced billing is prohibited), 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](http://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.

<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td><strong>Primary care visit to treat an injury or illness</strong></td>
<td><strong>Network provider (You will pay the least)</strong> $55 copay / office visit</td>
<td><strong>Out-of-network provider (You will pay the most)</strong> Not covered</td>
</tr>
<tr>
<td></td>
<td>Chiropractic visit</td>
<td><strong>Network provider (You will pay the least)</strong> $55 copay / office visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Specialist visit</strong></td>
<td><strong>Network provider (You will pay the least)</strong> $70 copay / office visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td><strong>Network provider (You will pay the least)</strong> No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td><strong>Diagnostic test (x-ray, blood work)</strong></td>
<td><strong>Network provider (You will pay the least)</strong> No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td><strong>Network provider (You will pay the least)</strong> 60% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td><strong>Generic drugs less than $6</strong></td>
<td><strong>Network provider (You will pay the least)</strong> $0 copay / prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td><strong>Generic drugs greater or equal to $6</strong></td>
<td><strong>Network provider (You will pay the least)</strong> $25 copay / prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td><strong>Network provider (You will pay the least)</strong> $75 copay / prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td><strong>Network provider (You will pay the least)</strong> $125 copay / prescription</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td><strong>Network provider (You will pay the least)</strong> $350 copay / prescription</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

More information about **prescription drug coverage** is available at sanfordhealthplan.com/pharmacy.

Office visit copay applies to the office visit charge and manual manipulation only. All other eligible modalities and therapies are subject to deductible / coinsurance.

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.

Select diagnostic x-rays, ultrasounds, specimens, and blood work done in an office visit setting that occur on the same date of service as your office visit copay. May be subject to deductible or coinsurance. Contact the Plan for full details on included benefits.

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 deductible or out-of-pocket limit. 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.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>60% coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>60% coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$65 copay / office visit</td>
<td>Additional services may be subject to deductible / coinsurance.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you need mental health, behavioral health, or substance abuse services</strong></td>
<td>Outpatient services</td>
<td>$55 copay / office visit and 60% coinsurance for other outpatient services after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td><strong>If you are pregnant</strong></td>
<td>Office visits</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

Certain outpatient services may require authorization (pre-approval) by the Plan. For a list of services, see the Prior Authorization list at sanfordhealthplan.com.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network provider (You will pay the least)</td>
<td>Out-of-network provider (You will pay the most)</td>
</tr>
<tr>
<td><strong>If you need help recovering or have other special health needs</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home health care</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
<td>Prior authorization required.</td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td>$55 copay / office visit and 60% coinsurance for other outpatient services after deductible</td>
<td>Not covered</td>
<td>Office visit copay covers evaluation. Therapies are subject to deductible / coinsurance.</td>
</tr>
<tr>
<td>Habilitation services</td>
<td>$55 copay / office visit and 60% coinsurance for other outpatient services after deductible</td>
<td>Not covered</td>
<td>Office visit copay covers evaluation. Therapies are subject to deductible / coinsurance.</td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
<td>Prior authorization required. Limited to 90 days in any consecutive 12 month period.</td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td>Hospice services</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
<td>None</td>
</tr>
<tr>
<td><strong>If your child needs dental or eye care</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>Not covered</td>
<td>Limited to 1 visit per calendar year. Benefit ends at the end of the month when the member turns 19.</td>
</tr>
<tr>
<td>Children’s glasses</td>
<td>60% coinsurance after deductible</td>
<td>Not covered</td>
<td>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.</td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>Not covered</td>
<td>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.</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Abortion</td>
</tr>
<tr>
<td>- Acupuncture</td>
</tr>
<tr>
<td>- Cosmetic surgery</td>
</tr>
<tr>
<td>- Dental care (Adult)</td>
</tr>
<tr>
<td>- Infertility treatment</td>
</tr>
<tr>
<td>- Long-term care</td>
</tr>
<tr>
<td>- Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>- Routine eye care (Adult)</td>
</tr>
<tr>
<td>- Weight loss programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn’t a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Bariatric Surgery</td>
</tr>
<tr>
<td>- Chiropractic Care</td>
</tr>
<tr>
<td>- Hearing aids</td>
</tr>
<tr>
<td>- Private-duty nursing</td>
</tr>
<tr>
<td>- Routine foot care</td>
</tr>
</tbody>
</table>

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 Division of Insurance at 1-605-773-3563, or the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272. 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): Dine!ehgo shika at’ohwoł ninisingo, kwiijigo 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**: $3,500
- **Specialist copayment**: $70
- **Hospital (facility) coinsurance**: 60%
- **Other coinsurance**: 60%

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$3,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$3,000</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $60

**The total Peg would pay is**: $6,570

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

- **The plan’s overall deductible**: $3,500
- **Specialist copayment**: $70
- **Hospital (facility) coinsurance**: 60%
- **Other coinsurance**: 60%

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,800</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $20

**The total Joe would pay is**: $1,920

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

- **The plan’s overall deductible**: $3,500
- **Specialist copayment**: $70
- **Hospital (facility) coinsurance**: 60%
- **Other coinsurance**: 60%

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:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$2,100</td>
</tr>
<tr>
<td>Copayments</td>
<td>$400</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$0</td>
</tr>
</tbody>
</table>

**What isn’t covered**

- Limits or exclusions: $0

**The total Mia would pay is**: $2,500

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:
  o Qualified sign language interpreters
  o 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:
  o Qualified interpreters
  o 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 koy, kog tej tuy neeg us koy pab ntawv, muaj lus nug txog Sanford Health Plan, koy mua ci kom lawv muab cov ntshiab lus chiang uas tau muab sau ua koy hom lus pub dawb rau koy. Yog koy 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 argachuuf fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakoofsa bilbilaa 1-844-927-2968 tiin bibilaa.

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 thể thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Đối 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.
Help understanding your health insurance is free.
If you would like something in another format (for example, a larger font size of a file for use with assistive technology), please call us at: (800) 752-5863 (toll-free) | TTY: 711

North Dakota Medicaid Expansion:
Please call (855) 305-5060 (toll-free) | TTY: 711