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, visit <a>sanfordhealthplan.com/sbcfinder</a> or call 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 <a>https://www.healthcare.gov/sbc-glossary/</a> or call 1-800-752-5863 to request a copy.

<table>
<thead>
<tr>
<th>Important Questions</th>
<th>Answers</th>
<th>Why This Matters</th>
</tr>
</thead>
<tbody>
<tr>
<td>What is the overall deductible?</td>
<td>For network providers $200 individual / $400 family. No out of network coverage. Copays do not apply to deductible.</td>
<td>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.</td>
</tr>
<tr>
<td>Are there services covered before you meet your deductible?</td>
<td>Yes. Preventive care and primary care services are covered before you meet your deductible.</td>
<td>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 &lt;a&gt;<a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>&lt;/a&gt;.</td>
</tr>
<tr>
<td>Are there other deductibles for specific services?</td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td>What is the out-of-pocket limit for this plan?</td>
<td>For network providers $1,250 individual / $2,500 family. No out of network coverage.</td>
<td>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.</td>
</tr>
<tr>
<td>What is not included in the out-of-pocket limit for this plan?</td>
<td>Premium, balance-billing charges, and health care this plan doesn’t cover.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td>Will you pay less if you use a network provider?</td>
<td>Yes. See &lt;a&gt;www.sanfordhealthplan.com&lt;/a&gt; or call 1-800-752-5863 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td>Do you need a referral to see a specialist?</td>
<td>No.</td>
<td>You can see the in-network specialist you choose without a referral.</td>
</tr>
</tbody>
</table>
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>Primary care visit to treat an injury or illness</td>
<td>$5 copay / office visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Chiropractic care</td>
<td>$5 copay / office visit</td>
<td>Office visit copay applies to the office visit charge and manual manipulation only. All other eligible modalities and therapies are subject to deductible / coinsurance.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$20 copay / office visit</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge</td>
<td>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.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>No charge</td>
<td>Some diagnostic x-rays, ultrasounds, specimens, and blood work done in an office visit setting that occur on the same date of service are included in your office visit copay. Additional services may be subject to deductible / coinsurance. Contact the Plan for full details on included benefits.</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>10% coinsurance after deductible</td>
<td>Prior authorization may be required.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs less than $6</td>
<td>$0 copay / prescription</td>
<td>Covers up to a 30-day supply.</td>
</tr>
<tr>
<td></td>
<td>Generic drugs greater equal to $6</td>
<td>$3 copay / prescription</td>
<td>Generic cost is based on total drug cost per 30-day supply.</td>
</tr>
<tr>
<td></td>
<td>Preferred brand drugs</td>
<td>$20 copay / prescription</td>
<td>Brand name drugs with generic equivalents require additional cost share. Difference in cost does not apply to deductible or out-of-pocket limit.</td>
</tr>
<tr>
<td></td>
<td>Non-preferred brand drugs</td>
<td>$40 copay / prescription</td>
<td>If the cost of the prescription falls under the copay amount, you will pay the least.</td>
</tr>
<tr>
<td></td>
<td>Specialty drugs</td>
<td>10% coinsurance after deductible</td>
<td>Refer to your Formulary to determine which benefit applies to your medication.</td>
</tr>
</tbody>
</table>

More information about prescription drug coverage is available at sanfordhealthplan.com/pharmacy.
<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>If you have outpatient surgery</td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>Network provider (You will pay the least) 10% coinsurance after deductible</td>
<td>Certain outpatient services may require authorization (pre-approval) by the Plan. For a list of services, see the Prior Authorization list at sanfordhealthplan.com.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>Out-of-network provider (You will pay the most)</td>
<td>None</td>
</tr>
<tr>
<td>If you need immediate medical attention</td>
<td>Emergency room care</td>
<td>10% coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Emergency medical transportation</td>
<td>10% coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Urgent care</td>
<td>$15 copay / office visit</td>
<td>Additional services may be subject to deductible / coinsurance.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>10% coinsurance after deductible</td>
<td>Prior authorization required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>10% coinsurance after deductible</td>
<td>None</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>$5 copay / office visit</td>
<td>Other outpatient services are subject to 10% coinsurance after deductible.</td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>10% coinsurance after deductible</td>
<td>Prior authorization required.</td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge</td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>10% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>10% coinsurance after deductible</td>
<td></td>
</tr>
<tr>
<td>Common Medical Event</td>
<td>Services You May Need</td>
<td>What You Will Pay</td>
<td>Limitations, Exceptions, &amp; Other Important Information</td>
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<tr>
<td>----------------------</td>
<td>-----------------------</td>
<td>-------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<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>If you need help recovering or have other special health needs</td>
<td>Home health care</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Rehabilitation services</td>
<td>$5 copay / office visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Habilitation services</td>
<td>$5 copay / office visit</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Skilled nursing care</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Durable medical equipment</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Hospice services</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td>If your child needs dental or eye care</td>
<td>Children’s eye exam</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s glasses</td>
<td>10% coinsurance after deductible</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td>Children’s dental check-up</td>
<td>No charge</td>
<td>Not covered</td>
</tr>
</tbody>
</table>
Excluded Services & Other Covered Services:

<table>
<thead>
<tr>
<th>Services Your 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>• Non-emergency care when traveling outside the U.S.</td>
</tr>
<tr>
<td>• Routine eye care (Adult)</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>• Long-term 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: 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 South Dakota Division of Insurance at 605-773-3563.

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? Not applicable.
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 tulog 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, kwijjigo 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.

<table>
<thead>
<tr>
<th>Peg is Having a Baby</th>
<th>Managing Joe’s type 2 Diabetes</th>
<th>Mia’s Simple Fracture</th>
</tr>
</thead>
<tbody>
<tr>
<td>9 months of in-network pre-natal care and a hospital delivery</td>
<td>(a year of routine in-network care of a well-controlled condition)</td>
<td>(in-network emergency room visit and follow up care)</td>
</tr>
</tbody>
</table>

- **Peg is Having a Baby**
  - The plan’s overall deductible: $200
  - Specialist copayment: $20
  - Hospital (facility) coinsurance: 10%
  - Other coinsurance: 10%

  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**:
  - Deductibles: $200
  - Copayments: $10
  - Coinsurance: $800

  **What isn’t covered**:
  - Limits or exclusions: $60

  **The total Peg would pay is**: $1,070

- **Managing Joe’s type 2 Diabetes**
  - The plan’s overall deductible: $200
  - Specialist copayment: $20
  - Hospital (facility) coinsurance: 10%
  - Other coinsurance: 10%

  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**:
  - Deductibles: $40
  - Copayments: $400
  - Coinsurance: $0

  **What isn’t covered**:
  - Limits or exclusions: $20

  **The total Joe would pay is**: $460

- **Mia’s Simple Fracture**
  - The plan’s overall deductible: $200
  - Specialist copayment: $20
  - Hospital (facility) coinsurance: 10%
  - Other coinsurance: 10%

  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**:
  - Deductibles: $200
  - Copayments: $70
  - Coinsurance: $200

  **What isn’t covered**:
  - Limits or exclusions: $0

  **The total Mia would pay is**: $470

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 køj, loog yog tej tus neeg uas køj pab ntawd, muaj lus nug txog Sanford Health Plan, køj muaj cai kom lawv muab cov ntsiab lus qhia uas tau muab sau ua køj hom lus pub dawb rau køj. Yog køj 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, lakkoofsaa 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 thể thong tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để nói chuyện với một thong 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.
If you would like something in another format (for example, a larger font size or file for use with assistive technology, like a screen reader), please call us: (800) 752-5863 (toll free) | TTY: 711

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