




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

www.sanfordhealthplan.com/sbcfinder or call 1-800-752-5863 (toll-free) | TTY/TDD: 711 (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 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 deductible?	For <u>network providers</u> \$6,000 individual / \$12,000 family No out-of-network coverage. Copays do not apply to deductible.	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 deductible?	Yes. <u>Preventive care</u> 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 <u>cost-sharing</u> and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at www.healthcare.gov/coverage/preventive-care-benefits .
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> \$9,200 individual / \$18,400 family No out-of-network coverage.	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 out-of-pocket limit?	<u>Premiums</u> , <u>balance-billing</u> charges (unless <u>balanced billing</u> is prohibited), 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 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 <u>provider</u> 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 <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 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 <u>copay</u> / visit	Not covered	None
	Chiropractic Visit	\$50 <u>copay</u> / visit	Not covered	None
	<u>Specialist</u> visit	\$120 <u>copay</u> / visit \$50 <u>copay</u> / visit for mental health and substance use primary diagnoses	Not covered	None
	<u>Preventive care/screening/immunization</u>	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed 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)	\$50 <u>copay</u>	Not covered	Certain services may be subject to <u>deductible</u> / <u>coinsurance</u> . For full details, refer to your plan document.
	Imaging (CT/PET scans, MRIs)	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization may be required.
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.sanfordhealthplan.com/pharmacy	Generic drugs less than \$6	\$0 <u>copay</u> / prescription	Not covered	Covers up to a 30-day supply. Brand name drugs with generic equivalents or biosimilar alternatives 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 that apply toward cost-sharing obligations (ex. deductibles, coinsurance, or copays) if used in conjunction with our current benefit offering. If the cost of the prescription falls under the <u>copay</u> amount, you will pay the least. Refer to your <u>Formulary</u> to determine which benefit applies to your medication.
	Generic drugs greater than \$6	\$40 <u>copay</u> / prescription	Not covered	
	Preferred brand drugs	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	
	Non-preferred brand drugs	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	
	Generic specialty drugs	\$40 <u>copay</u> / prescription	Not covered	
	Preferred specialty drugs	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	
	Non-preferred specialty drugs	60% <u>coinsurance</u> after <u>deductible</u>	Not covered	

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 have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	Certain outpatient services may require authorization (pre-approval) by the <u>plan</u> . For a list of services, see the Prior Authorization list at www.sanfordhealthplan.com .
	Physician/surgeon fees	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	None
If you need immediate medical attention	<u>Emergency room care</u>	40% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Emergency medical transportation</u>	40% <u>coinsurance</u> after <u>deductible</u>	40% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Urgent care</u>	\$65 <u>copay</u> / visit \$50 <u>copay</u> / visit for mental health and substance use primary diagnoses	60% <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)	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization required.
	Physician/surgeon fees	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: \$50 <u>copay</u> / visit Other Outpatient Services: 40% <u>coinsurance</u> after <u>deductible</u>	Not covered	First 5 office visits covered at 100% in the combined categories of Mental/Behavioral Health and SUD.
	Inpatient services	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization required.
If you are pregnant	Office visits	No charge	Not covered	<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).
	Childbirth/delivery professional services	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	
	Childbirth/delivery facility services	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	

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 need help recovering or have other special health needs	<u>Home health care</u>	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization required.
	<u>Rehabilitation services</u>	Office Visit: \$50 <u>copay</u> / visit Other Outpatient Services: 40% <u>coinsurance</u> after <u>deductible</u>	Not covered	Office visit <u>copay</u> covers evaluation. Therapies are subject to <u>deductible</u> / <u>coinsurance</u> .
	<u>Habilitation services</u>	Office visit: \$50 <u>copay</u> Other Outpatient Services: 40% <u>coinsurance</u> after <u>deductible</u>	Not covered	Office visit <u>copay</u> covers evaluation. Therapies are subject to <u>deductible</u> / <u>coinsurance</u> .
	<u>Skilled nursing care</u>	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization required. Limited to 90 days in any consecutive 12-month period.
	<u>Durable medical equipment</u>	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	Prior authorization may be required.
	<u>Hospice services</u>	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	Hospice respite care limited to 15 inpatient and 15 outpatient days per lifetime. Hospice respite care must be used in increments of not more than 5 days at a time.
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	Limited to 1 visit per calendar year. Benefit ends at the end of the month when the member turns 19.
	Children's glasses	40% <u>coinsurance</u> after <u>deductible</u>	Not covered	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	Not covered	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 .

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.)

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

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|---------------------|----------------|------------------------|
| • Bariatric Surgery | • Hearing aids | • Private-duty nursing |
| • Chiropractic Care | | • Routine foot care |

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 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 & Grievances 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 the 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 1-800-752-5863 (*toll-free*).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-752-5863 (*toll-free*).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码 1-800-752-5863 (*toll-free*).

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwijigo holne' 1-800-752-5863 (*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** \$6,000
- **Specialist copayment** \$120
- **Hospital (facility) coinsurance** 40%
- **Other coinsurance** 40%

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
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In this example, Peg would pay:

Cost Sharing	
<u>Deductibles</u>	\$6,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,000
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$7,060

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

- **The plan's overall deductible** \$6,000
- **Specialist copayment** \$120
- **Hospital (facility) coinsurance** 40%
- **Other coinsurance** 40%

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
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In this example, Joe would pay:

Cost Sharing	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,100
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

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

- **The plan's overall deductible** \$6,000
- **Specialist copayment** \$120
- **Hospital (facility) coinsurance** 40%
- **Other coinsurance** 40%

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
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In this example, Mia would pay:

Cost Sharing	
<u>Deductibles</u>	\$2,100
<u>Copayments</u>	\$500
<u>Coinsurance</u>	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$2,600

Non-discrimination notice

Sanford Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law. Sanford Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, sex (including pregnancy, sexual orientation, and gender identity), or any other classification protected under the law.

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, 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, call (800) 752-5863 (TTY: 711)

If you believe that Sanford Health Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex (including pregnancy, sexual orientation, and gender identity), you can file a grievance with the Section 504 Coordinator at:

Mailing Address: Section 504 Coordinator
2301 E. 60th Street, Sioux Falls, SD 57103
Telephone number: (877) 473-0911 (TTY: 711)
Fax: (605) 312-9886
Email: shpcompliance@sanfordhealth.org

You can file a grievance in person or by phone, mail, fax, or email. If you need help filing a grievance, the Section 504 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, D.C. 20201
(800) 368-1019, (800) 537-7697 (TDD)

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

Help in Other Languages

For help in any language other than English, call (800) 752-5863 (TTY: 711).

Arabic -

خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن (رقم هاتف الصم والبكم: 711) (800) 752-5863

Amharic - ማስታወሻ: የሚናገሩት ቋንቋ ካማርኛ ከሆነ የትርጉም አገልግሎት ድርጅቶቻችን ለዎቹ የሚናገሩት ቋንቋ ካማርኛ ከሆነ የትርጉም አገልግሎት ድርጅቶቻችን በነጻ ሊያገዝዎት ተዘጋጅተዋል። ወደ ሚከተለው ቁጥር ይደውሉ (800) 752-5863 (መስማት ለተሳናቸው: 711)።

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 (800) 752-5863 (TTY: 711)。

Cushite (Oromo) - XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (800) 752-5863 (TTY: 711).

German - ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (800) 752-5863 (TTY: 711).

Hmong - LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 752-5863 (TTY: 711).

Karen - ၵာ်သုၣ်တၢ်သး- နမ့ၢ်ကတိၤ ကညီ ကျိၣ်အသိၤ, နမ့ၢ်န့ၢ် ကျိၣ်အတၢ်မၤတၢ်လၢ တၢ်လၢတၢ်တူၣ်လၢတၢ်စ့ၤ နီတမံၤဘၣ်သ့န့ၢ်လီၤ. ကိး (800) 752-5863 (TTY: 711).

Korean - 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (800) 752-5863 (TTY: 711) 번으로 전화해 주십시오.

Laotian - ໄປ່ດຊາຍ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານ ພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທສ (800) 752-5863 (TTY: 711).

French - ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (800) 752-5863 (TTY: 711).

Russian - ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 752-5863 (телетайп: 711).

Spanish - ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (800) 752-5863 (TTY: 711).

Tagalog - PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa (800) 752-5863 (TTY: 711).

Thai - เร็ยูน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้ บริการช่วยเหลือทางภาษาได้ ฟรี โทร (800) 752-5863 (TTY: 711).

Vietnamese - CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (800) 752-5863 (TTY: 711).