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 network providers **$2,000** individual / **$4,000** family For out-of-network providers **$8,000** individual / **$16,000** family **Copays do not apply to deductible.**	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Preventive 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 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 **$3,150** individual / **$6,300** family For out-of-network providers **$19,500** individual / **$39,000** family	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** 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.

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	$15 copay / visit (deductible does not apply)	70% coinsurance after deductible	First 5 office visits covered at 100% in the combined categories of Primary Care, Habilitation, or Rehabilitation.
	Chiropractic Visit	$15 copay / visit (deductible does not apply)	70% coinsurance after deductible	Limited to 20 visits per calendar year.
	Specialist visit	$65 copay / visit (deductible does not apply) $15 copay / visit for mental health and substance use primary diagnoses (deductible does not apply)	70% coinsurance after deductible	None
	Preventive care/screening/ immunization	No charge	70% coinsurance after deductible	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	$15 copay (deductible does not apply)	70% coinsurance after deductible	Certain services may be subject to deductible / coinsurance. For full details, refer to your plan document.
	Imaging (CT/PET scans, MRIs)	30% coinsurance after deductible	70% coinsurance after deductible	Prior authorization may be required.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.sanfordhealthplan.com /pharmacy	Generic drugs less than $6	$0 copay / prescription (deductible does not apply)	Not covered	Covers up to a 30-day supply. Brand drugs with generic equivalents or biosimilar alternatives 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 that apply toward cost-sharing obligations if used in conjunction with our current benefit offering. If the drug cost is less than the copay, you will pay the lower amount. Refer to your Formulary for coverage details – drug
	Generic drugs greater than $6	$10 copay / prescription (deductible does not apply)	Not covered	
	Preferred brand drugs	$20 copay / prescription (deductible does not apply)	Not covered	
	Non-preferred brand drugs	25% coinsurance after deductible	Not covered	
	Generic specialty drugs	$10 copay / prescription (deductible does not apply)	Not covered	
	Preferred specialty drugs	30% coinsurance after deductible	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)	
	Non-preferred specialty drugs	65% coinsurance after deductible	Not covered	listings and tier placements are subject to change with prior notice.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance after deductible	70% coinsurance after deductible	Certain outpatient services may require authorization (pre-approval) by the plan. For a list of services, see the Prior Authorization list at www.sanfordhealthplan.com.
	Physician/surgeon fees	30% coinsurance after deductible	70% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	30% coinsurance after deductible	30% coinsurance after deductible	None
	Emergency medical transportation	30% coinsurance after deductible	30% coinsurance after deductible	None
	Urgent care	$30 copay / visit (deductible does not apply) $15 copay / visit for mental health and substance use primary diagnoses (deductible does not apply)	70% coinsurance after deductible	Additional services may be subject to deductible / coinsurance.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance after deductible	70% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	30% coinsurance after deductible	70% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office Visit: $15 copay / visit (deductible does not apply) Other Outpatient Services: 30% coinsurance after deductible	70% coinsurance after deductible	First 5 office visits covered at 100% in the combined categories of Mental/Behavioral Health and SUD.
	Inpatient services	30% coinsurance after deductible	70% coinsurance after deductible	Prior authorization required.
If you are pregnant	Office visits	No charge	70% coinsurance after deductible	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
	Childbirth/delivery professional services	30% coinsurance after deductible	70% coinsurance after deductible	

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)	
	Childbirth/delivery facility services	30% coinsurance after deductible	70% coinsurance after deductible	apply. Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
If you need help recovering or have other special health needs	Home health care	30% coinsurance after deductible	70% coinsurance after deductible	Prior authorization may be required. Limited to 40 visits per calendar year.
	Rehabilitation services	Office Visit: $15 copay / visit (deductible does not apply) Other Outpatient Services: 30% coinsurance after deductible	70% coinsurance after deductible	First 5 office visits covered at 100% in the combined categories of Primary Care, Habilitation, or Rehabilitation. Office visit copay covers evaluation. Therapies are subject to deductible / coinsurance. Limited to 30 visits per calendar year.
	Habilitation services	Office Visit: $15 copay / visit (deductible does not apply) Other Outpatient Services: 30% coinsurance after deductible	70% coinsurance after deductible	First 5 office visits covered at 100% in the combined categories of Primary Care, Habilitation, or Rehabilitation. Office visit copay covers evaluation. Therapies are subject to deductible / coinsurance. Limited to 30 visits per calendar year.
	Skilled nursing care	30% coinsurance after deductible	70% coinsurance after deductible	Prior authorization required. Limited to 30 days in any consecutive 12-month period.
	Durable medical equipment	30% coinsurance after deductible	70% coinsurance after deductible	Prior authorization may be required.
	Hospice services	30% coinsurance after deductible	70% coinsurance after deductible	None
If your child needs dental or eye care	Children's eye exam	No charge	70% coinsurance after deductible	Limited to 1 visit per calendar year. Benefit ends at the end of the month when the member turns 19.
	Children's glasses	30% coinsurance after deductible	70% coinsurance after deductible	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.

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)	
	Children's dental check-up	No charge	70% coinsurance after deductible	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	• Private duty nursing
• Cosmetic surgery	• Long-term care	• Routine eye 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	• Routine foot care
• Chiropractic 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: 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 North Dakota Insurance Department at 1-800-247-0560.

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, kwiijigo 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	$2,000
Specialist copayment	$65
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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:

Cost Sharing	
Deductibles	$2,000
Copayments	$0
Coinsurance	$1,300
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,360**

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

The plan's overall deductible	$2,000
Specialist copayment	$65
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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:

Cost Sharing	
Deductibles	$100
Copayments	$700
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$820**

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

The plan's overall deductible	$2,000
Specialist copayment	$65
Hospital (facility) coinsurance	30%
Other coinsurance	30%

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:

Cost Sharing	
Deductibles	$2,000
Copayments	$200
Coinsurance	$30
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,230**

Non-discrimination notice

SANFORD HEALTH PLAN

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

(800) 752-5863 (رقم هاتف الصم والبكم: 711)

Amharic – ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶችማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ 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 – ဟ်သူဉ်ဟ်သး– နမ့၎ကတိၤ ကညီ ကျိာ်အယိ, နမၤန့၎ ကျိာ်အတ၎မၤစၢၤလၢ တလၢာ်ဘူဉ်လၢာ်စ့ၤ နီတမံၤဘဉ်သ့နှဉ်လီၤ. 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 – ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານ ພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ (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 – เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี 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).