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 drugs to treat your illness or condition More information about **prescription drug coverage** is available at sanfordhealthplan.com/memberlogin	Generic drugs	No charge	Not covered	Covers up to a 30-day supply. Certain contraceptive drugs covered at 100%. Brand name drugs with generic equivalents require additional cost share. Refer to your Formulary to determine which benefit applies to your medication.
	Brand drugs	$3 copay/prescription	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced or denied.
	Physician/surgeon fees	No charge	Not covered	
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	
	Urgent care	$3 copay/visit	$3 copay/visit	
If you have a hospital stay	Facility fee (e.g., hospital room)	$75 copay per stay	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced or denied.
	Physician/surgeon fees	No charge	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 mental health, behavioral health, or substance abuse services	Outpatient services	$2 copay/office visit and no charge for other outpatient services	Not covered	None
	Inpatient services	$75 copay per stay	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced or denied. For Members ages 21 and older, no coverage at an Institution for Mental Disease (IMD); benefit limited only to certain facilities. For full details, please refer to your Certificate of Coverage.
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Depending on the type of services, copayment/ coinsurance may apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	Limited to 40 visits per calendar year. Preauthorization is required. If you don't get preauthorization, benefits could be reduced or denied.
	Rehabilitation services	$2 copay/office visit for Physical and Occupational Therapy $1 copay/office visit for Speech Therapy	Not covered	Limited to 30 visits per therapy per calendar year for Members 21 and older.
	Habilitation services	$2 copay/office visit for Physical and Occupational Therapy $1 copay/office visit for Speech Therapy	Not covered	Limited to 30 visits per therapy per calendar year for Members 21 and older.

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 (con't)	Skilled nursing care	No charge	Not covered	Limited to 30 days in any consecutive 12-month period. Preauthorization is required. If you don't get preauthorization, benefits could be reduced or denied.
	Durable medical equipment	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced or denied.
	Hospice services	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, benefits could be reduced or denied.
If you are ages 19 and 20, and need routine dental or eye care	Routine eye exam	No charge	Not covered	Limited to 1 visit per calendar year. Benefit applies until end of month member turns 21.
	Glasses	No charge	Not covered	Frames limited to 1 item every other year. Lenses or contact lenses limited to 1 item annually. Benefit applies until end of month member turns 21.
	Routine dental check-up	No charge	Not covered	Limited to four (4) visits per calendar year. Includes diagnostic, preventive, restorative, and endodontic services; periodontics, prosthodontics, oral and maxillofacial surgery, medically necessary orthodontics, and adjunctive general services. Benefit applies until end of month member turns 21.

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
- Care provided outside the United States
- Cosmetic surgery
- Dental care (unless for Members ages 19 and 20)
- Hearing aids (unless for Members ages 19 and 20; or for cochlear or bone-anchored implants prescribed by a physician)
- Infertility treatment
- Inpatient Services received at an Institution for Mental Diseases (IMD) (unless for Members ages 19 and 20)
- Long-term care
- Prescriptions filled at a pharmacy not in the Health Plan network
- Room and board at Residential Treatment Facilities for Members ages 21 and older
- Routine eye care (unless for Members ages 19 and 20)
- 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	• Non-Emergency Medical Transportation	• Routine foot care (for diabetics only)
• Chiropractic Care	• Private-duty nursing	• Telehealth / e-visits / video visits

Your Rights to Continue Coverage:
North Dakotans who have been denied public assistance benefits or whose benefits are reduced, terminated, discontinued, or suspended may appeal a decision in certain circumstances. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

If you would like your coverage to continue while you appeal, you must request this in writing within 10 days of the denial decision. For more information on your rights to continue coverage, contact the insurer at 1-855-305-5060 *(toll-free)*| TTY/TDD: 1-877-652-1844 *(toll-free)*.You may also contact North Dakota Medical Services at 1-844-854-4825 *(toll-free)* or TTY/TDD: 1-800-366-6888 *(toll-free)*.

Your Grievance and Appeals Rights: If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact Sanford Health Plan/Customer Service toll-free at 1-855-305-5060 | TTY/TDD: (877) 652-1844 *(toll-free)* or North Dakota Medical Services at 1-844-854-4825 *(toll-free)*.

Does this plan provide Minimum Essential Coverage? Yes. If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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, 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	$0
Specialist copayment	$2
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$0
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$60**

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

The plan's overall deductible	$0
Specialist copayment	$2
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$60
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$120**

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

The plan's overall deductible	$0
Specialist copayment	$2
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	**$1,930**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$10**

NOTE: ***This Plan does not cover babies**. This example shows what your costs might be if you had a baby while covered under Medicaid Expansion. If you are pregnant, you may be eligible for other options under traditional Medicaid. Contact your local county social services office for more information.