



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, sanfordhealthplan.com/sbcfinder or by calling **1-800-752-5863 (toll free)** | TTY/TDD: **1-877-652-1844 (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 <https://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> \$4,750 individual / \$9,500 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> and primary care 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 cost-sharing and before you meet your <u>deductible</u> . See a list of covered <u>preventive services</u> at https://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> \$8,150 individual / \$16,300 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, and health care this <u>plan</u> 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 <u>network providers</u> . | This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a provider 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 provider for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (balance billing). 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 provider 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> . |

Provider Network: Focused



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 <u>provider's</u> office or clinic | Primary care visit to treat an injury or illness | \$55 <u>copay</u> / visit | Not covered | None |
| | Chiropractic visit | \$55 <u>copay</u> / visit | Not covered | Office visit <u>copay</u> applies to the office visit charge and manual manipulation only. All other eligible modalities and therapies are subject to <u>deductible</u> / <u>coinsurance</u> . |
| | <u>Specialist</u> visit | \$55 <u>copay</u> / visit | Not covered | None |
| | <u>Preventive care/screening/immunization</u> | No charge | Not covered | You may have to pay for services that aren't part of the <u>preventive</u> health guidelines. Ask your <u>provider</u> if these services you need 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) | No charge | Not covered | 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 <u>deductible</u> / <u>coinsurance</u> . Contact the Plan for full details on included benefits. |
| | Imaging (CT/PET scans, MRIs) | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | None |

| 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/pharmacy | Generic drugs less than \$6 | \$0 <u>copay</u> / prescription | Not covered | 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 <u>deductible</u> or <u>out-of-pocket limit</u> . If the cost of the prescription falls under the copay amount, you will pay the least. Refer to your <u>Formulary</u> to determine which benefit applies to your medication. |
| | Generic drugs greater or equal to \$6 | \$25 <u>copay</u> / prescription | | |
| | Preferred brand drugs | \$75 <u>copay</u> / prescription | Not covered | |
| | Non-preferred brand drugs | \$125 <u>copay</u> / prescription | Not covered | |
| | Specialty drugs | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | Certain outpatient services may require authorization (pre-approval) by the Plan. For a list of services, see the Prior Authorization list at sanfordhealthplan.com . |
| | Physician/surgeon fees | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | None |
| If you need immediate medical attention | Emergency room care | 50% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | None |
| | Emergency medical transportation | 50% <u>coinsurance</u> after <u>deductible</u> | 50% <u>coinsurance</u> after <u>deductible</u> | None |
| | Urgent care | \$55 <u>copay</u> / visit | \$55 <u>copay</u> / visit | Additional services may be subject to <u>deductible</u> / <u>coinsurance</u> . |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | Prior authorization required. |
| | Physician/surgeon fees | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | None |

| 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 Office visit: \$55 <u>copay</u> / visit Other outpatient services: 50% <u>coinsurance</u> after <u>deductible</u> | | Not covered | None |
| | Inpatient services | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | Prior authorization required. |
| If you are pregnant | Office visits | No charge | Not covered | Cost sharing 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 | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | |
| | Childbirth/delivery facility services | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | |
| If you need help recovering or have other special health needs | <u>Home health care</u> | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | Prior authorization required. |
| | <u>Rehabilitation services</u> Office visit: \$55 <u>copay</u> / visit Other outpatient services: 50% <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: \$55 <u>copay</u> / visit Other outpatient services: 50% <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> | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | Prior authorization required. Limited to 90 days in any consecutive 12 month period. |

| 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>Durable medical equipment</u> | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | Prior authorization may be required. |
| | <u>Hospice services</u> | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | None |
| If your child needs dental or eye care | Children's eye exam | No charge | Not covered | Limited to 1 visit per calendar year. Until end of month member turns 19. |
| | Children's glasses | 50% <u>coinsurance</u> after <u>deductible</u> | Not covered | Frames limited to 1 item every other year. Lenses or contact lenses limited to 1 item annually. Until end of month member turns 19. |
| | Children's dental check-up Preventive dental services: Other dental services: | No charge 50% <u>coinsurance</u> (<u>deductible</u> does not apply) | Not covered | Routine check-ups limited to 2 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.)

- | | | |
|-----------------------|-------------------------|--|
| • Acupuncture | • Infertility treatment | • Non-emergency care when traveling outside the U.S. |
| • Cosmetic surgery | • Long-term care | • Routine eye care (Adult) |
| • Dental 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 (except for gradual deterioration of hearing that occurs with aging and/or other lifestyle factors) | • Private-duty nursing |
| • Chiropractic Care | | • Routine foot care (for diabetics only) |
| | | • Telehealth / e-visits / video visits |

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 Department of Labor at 1-605-773-3101. 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 & 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.**

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, kwijijigo 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 **\$4,750**
- Specialist copayment **\$55**
- Hospital (facility) coinsurance **50%**
- Other coinsurance **50%**

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:

| <i>Cost Sharing</i> | |
|---------------------|---------|
| Deductibles | \$4,750 |
| Copayments | \$40 |
| Coinsurance | \$2,100 |

| <i>What isn't covered</i> | |
|---------------------------|------|
| Limits or exclusions | \$60 |

| | |
|-----------------------------------|----------------|
| The total Peg would pay is | \$6,950 |
|-----------------------------------|----------------|

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

- The plan's overall deductible **\$4,750**
- Specialist copayment **\$55**
- Hospital (facility) coinsurance **50%**
- Other coinsurance **50%**

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:

| <i>Cost Sharing</i> | |
|---------------------|---------|
| Deductibles | \$10 |
| Copayments | \$2,600 |
| Coinsurance | \$0 |

| <i>What isn't covered</i> | |
|---------------------------|------|
| Limits or exclusions | \$60 |

| | |
|-----------------------------------|----------------|
| The total Joe would pay is | \$2,670 |
|-----------------------------------|----------------|

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

- The plan's overall deductible **\$4,750**
- Specialist copayment **\$55**
- Hospital (facility) coinsurance **50%**
- Other coinsurance **50%**

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 | \$1,900 |
|---------------------------|----------------|

In this example, Mia would pay:

| <i>Cost Sharing</i> | |
|---------------------|---------|
| Deductibles | \$1,300 |
| Copayments | \$400 |
| Coinsurance | \$0 |

| <i>What isn't covered</i> | |
|---------------------------|-----|
| Limits or exclusions | \$0 |

| | |
|-----------------------------------|----------------|
| The total Mia would pay is | \$1,700 |
|-----------------------------------|----------------|

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 our Civil Rights Coordinator.

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 our Director of Customer Service, 300 Cherapa Place #201, Sioux Falls, SD 57103, (800) 752-5863, TTY/TDD (877) 652-1844, fax (605) 328-6812, memberservices@sanfordhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights 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, DC 20201, (800) 368-1019, (800) 537-7697 (TDD).

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

Free help in other languages

For help in a language other than English, please call us toll-free at (800) 892-0675. Both oral and written translation services are available for free in at least 150 languages. If you have any questions, for example, about your benefits, this document, or how Sanford Health Plan pays for your care, please call us.

English: ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-892-0675 (TTY: 1-877-652-1844).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-892-0675 (TTY: 1-877-652-1844).

Hmong: LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-800-892-0675 (TTY: 1-877-652-1844).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-892-0675 (TTY: 1-877-652-1844).

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-892-0675 (TTY: 1-877-652-1844).

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 1-800-892-0675 (TTY: 1-877-652-1844)。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-892-0675 (TTY: 1-877-652-1844).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-892-0675 (телетайп: 1-877-652-1844)

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັຽຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທ 1-800-892-0675 (TTY: 1-877-652-1844).

Arabic: خدمات فإن، اللغة اذكر تتحدث كنت إذا: ملحوظة 1-877-652-1844 (رقم) والبكم الصم هاتف 1-800-892-0675 برقم اتصل. بالمجان لك تتوافر اللغوية المساعدة

Karen:

ဟံသုဉ်ဟံသး- နမုာ်ကတိာ် ကညီ ကျိဉ်အထိ, နမုာ်န့ၢ် ကျိဉ်အတၢ်မၤစၢၤလၢ တလၢာ်ဘျုးလၢာ်စ့ၤ နီတၢ်စၢၤဘျုးသုန့ၢ်လီၤ. ကိ: 1-800-892-0675 (TTY: 1-877-652-1844).

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያገለግሉት ተዘጋጅተዋል። ወደ ሚክተለው ቁጥር ይደውሉ 1-800-892-0675 (መስማት ለተሳናቸው: 1-877-652-1844)።

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-892-0675 (TTY: 1-877-652-1844). 번으로 전화해 주십시오.

French: ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-892-0675 (ATS : 1-877-652-1844).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-892-0675 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-877-652-1844).

Cambodian, Mon-Khmer:

សម្រាប់: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ ចូរ ទូរស័ព្ទ 1-800-892-0675 (TTY: 1-877-652-1844)។

Help understanding this document is free

If you would like this policy in another format (for example, a larger font size of a file for use with assistive technology, like a screen reader), please call us at:
(800) 752-5863 (toll-free) | TTY/TDD: (877) 652-1844