SANFORD HEALTH PLAN

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services

Simplicity Individual Silver $3,500 73% | North Dakota **Coverage Period Beginning on or after: 01/01/2024**

Coverage for: Individual + Family | **Plan Type:** PPO | Non-Grandfathered

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 **sanfordhealthplan.com/sbcfinder** or call **1-800-752-5863** *(toll free)* | TTY/TDD: **711**. 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 network providers **$3,500** individual / **$7,000** family. For out-of-network providers **$7,000** individual / **$14,000** 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 and primary 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 https://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 **$7,250** individual / **$14,500** family. For out-of-network providers **$18,200** individual / **$36,400** 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 for this plan?	Premium, 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.	You will pay the least if you use a provider in the Sanford Preferred network. You pay more if you use a provider in the Affiliated 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.

Provider Network: Broad

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies. For mental health and substance use disorder conditions, visit limits do not apply.
Sanford Preferred Providers: Sanford Health Practitioners and/or Facilities. With Sanford Preferred Providers, you will pay Tier-1 In-Network Benefits.
Affiliated Providers: All other In-Network Practitioners and/or facilities. With Affiliated Providers, you will pay Tier-2 In-Network Benefits.

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	**Sanford Preferred:** $40 copay / office visit **Affiliated:** $60 copay / office visit	70% coinsurance after deductible	None
	Chiropractic visit	**Sanford Preferred or Affiliated:** $40 copay / office visit	70% coinsurance after deductible	Office visit copay applies to the office visit charge and manual manipulation only. All other eligible modalities and therapies are subject to deductible / coinsurance. Limited to 20 visits per calendar year.
	Specialist visit	**Sanford Preferred:** $60 copay / office visit **Affiliated:** $75 copay / office visit $40 copay / office visit for mental health and substance use primary diagnoses	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 part of the preventive health guidelines. Ask your provider if these services you need are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	**Sanford Preferred or Affiliated:** $40 copay	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)	**Sanford Preferred or Affiliated:** 40% coinsurance after deductible	70% coinsurance after deductible	Prior authorization may be required.

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 copay / 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 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 if used in conjunction with our current benefit offering. If the cost of the prescription falls under the copay amount, you will pay the least. Refer to your Formulary to determine which benefit applies to your medication.
	Generic drugs greater or equal to $6	$30 copay / prescription	Not covered	
	Preferred brand drugs	$40 copay / prescription	Not covered	
	Non-preferred brand drugs	$150 copay / prescription	Not covered	
	Generic specialty drugs	$30 copay / prescription	Not covered	
	Preferred specialty drugs	40% coinsurance after deductible	Not covered	
	Non-preferred specialty drugs	65% coinsurance after deductible	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	**Sanford Preferred or Affiliated:** 40% 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 sanfordhealthplan.com.
	Physician/surgeon fees	**Sanford Preferred or Affiliated:** 40% coinsurance after deductible	70% coinsurance after deductible	None
If you need immediate medical attention	Emergency room care	40% coinsurance after deductible	40% coinsurance after deductible	None
	Emergency medical transportation	40% coinsurance after deductible	40% coinsurance after deductible	None
	Urgent care	$55 copay / office visit $40 copay / office visit for mental health and substance use primary diagnoses	$55 copay / office visit 0% coinsurance for mental health and substance use primary diagnoses	Additional services may be subject to deductible / coinsurance.

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 a hospital stay	Facility fee (e.g., hospital room)	**Sanford Preferred or Affiliated:** 40% coinsurance after deductible	70% coinsurance after deductible	Prior authorization required.
	Physician/surgeon fees	**Sanford Preferred or Affiliated:** 40% coinsurance after deductible	70% coinsurance after deductible	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	**Sanford Preferred or Affiliated:** $40 copay / office visit Other Outpatient Services 40% coinsurance after deductible	70% coinsurance after deductible	None
	Inpatient services	**Sanford Preferred or Affiliated:** 40% 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 apply. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	**Sanford Preferred or Affiliated:** 40% coinsurance after deductible	70% coinsurance after deductible	
	Childbirth/delivery facility services	**Sanford Preferred or Affiliated:** 40% 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)	
If you need help recovering or have other special health needs	Home health care	**Sanford Preferred or Affiliated:** 40% coinsurance after deductible	70% coinsurance after deductible	Prior authorization required. Limited to 40 visits per calendar year.
	Rehabilitation services	**Sanford Preferred or Affiliated:** $40 copay / office visit Other Outpatient Services 40% coinsurance after deductible	70% coinsurance after deductible	Office visit copay covers evaluation. Limited to 30 visits per calendar year.
	Habilitation services	**Sanford Preferred or Affiliated:** $40 copay / office visit Other Outpatient Services 40% coinsurance after deductible	70% coinsurance after deductible	Office visit copay covers evaluation. Limited to 30 visits per calendar year.
	Skilled nursing care	**Sanford Preferred or Affiliated:** 40% coinsurance after deductible	70% coinsurance after deductible	Prior authorization required. Limited to 30 days in any consecutive 12-month period.
	Durable medical equipment	**Sanford Preferred or Affiliated:** 40% coinsurance after deductible	70% coinsurance after deductible	Prior authorization may be required.
	Hospice services	**Sanford Preferred or Affiliated:** 40% coinsurance after deductible	70% coinsurance after deductible	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 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	**Sanford Preferred or Affiliated:** 40% 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.
	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 Generally Does NOT Cover (Check your policy or 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 document.)		
• 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: 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 & 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 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 1-800-752-5863 (*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 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**	**$3,500**
■ **Specialist copayment**	**$60**
■ **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**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$3,500
Copayments	$10
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$3,570**

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

■ **The plan's overall deductible**	**$3,500**
■ **Specialist copayment**	**$60**
■ **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**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$100
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,620**

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

■ **The plan's overall deductible**	**$3,500**
■ **Specialist copayment**	**$60**
■ **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**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$2,100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

The plan would be responsible for the other costs of these EXAMPLE covered services.