



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, <https://ndpers.nd.gov/image/cache/shp-coi-hdhp.pdf> or by calling 1-800-499-3416 (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 <https://www.healthcare.gov/sbc-glossary/> or call 1-800-499-3416 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall <u>deductible</u> ?	PPO Providers: \$2,000 individual / \$4,000 family. Basic Providers: \$2,000 individual / \$4,000 family.	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> , the overall <u>deductible</u> must be met before the <u>plan</u> begins to pay.
Are there services covered before you meet your <u>deductible</u> ?	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 <u>cost-sharing</u> 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 <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this plan?	PPO Providers: \$3,500 individual / \$7,000 family. Basic Providers: \$4,000 individual / \$8,000 family.	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> , the overall family <u>out-of-pocket limit</u> must be met.
What is not included in the <u>out-of-pocket limit</u> ?	<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 <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.sanfordhealthplan.com or call 1-800-499-3416 for a list of <u>network providers</u> .	This <u>plan</u> uses a <u>provider</u> network. You will pay less if you use a <u>provider</u> in the plan's network. 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 provider's 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 <u>referral</u> to see a <u>specialist</u> ?	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
		<u>PPO Plan</u>	<u>Basic Plan</u>	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Specialist</u> visit	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Preventive care/screening/Immunization</u>	No charge	No charge	You may have to pay for services that aren't <u>preventive</u> . Ask your <u>provider</u> if these services you need are preventive. Then check what your <u>plan</u> will pay.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	None
	Imaging (CT/PET scans, MRIs)	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	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 sanfordhealthplan.com/pharmacy	Formulary Drugs	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	Prescription Medications or Drugs and nonprescription diabetes supplies are subject to a dispensing limit of 100-day supply. Insulin and medical supplies for insulin dosing and administration \$25 copay per 30-day supply. Deductible amount is waived for insulin only. Refer to your <u>Formulary</u> to determine which benefit applies to your medication. Certain contraceptive drugs covered at 100%.
	Non-Formulary Drugs	50% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	These services may require preauthorization / prior approval by the Health Plan.
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan	Basic Plan	
If you need immediate medical attention	<u>Emergency room care</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Emergency medical transportation</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	None
	<u>Urgent care</u>	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	None
If you have a hospital stay	Facility fee (e.g., hospital room)	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required.
	Physician/surgeon fees	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	20% <u>coinsurance</u> after <u>deductible</u>	20% <u>coinsurance</u> after <u>deductible</u>	None
	Inpatient services	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required.
If you are pregnant	Office visits	No charge	No charge	Routine prenatal and postnatal visits are covered under your Preventive Health Care Services benefit. <u>Deductible</u> is waived.
	Childbirth/delivery professional services	20% <u>coinsurance</u>	25% <u>coinsurance</u>	
	Childbirth/delivery facility services	20% <u>coinsurance</u>	25% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required.
	<u>Rehabilitation services</u>	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	For full details, please refer to your <u>plan</u> document.
	<u>Habilitation services</u>	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	For full details, please refer to your <u>plan</u> document.
	<u>Skilled nursing care</u>	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		<u>PPO Plan</u>	<u>Basic Plan</u>	
If you need help recovering or have other special health needs	<u>Durable medical equipment</u>	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	Prior authorization may be required.
	<u>Hospice services</u>	20% <u>coinsurance</u> after <u>deductible</u>	25% <u>coinsurance</u> after <u>deductible</u>	None
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	None
	Children's glasses	Not covered	Not covered	None
	Children's dental check-up	Not covered	Not covered	None

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 | • Dental care (Adult) | • 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.)

- | | | |
|---------------------|--|--|
| • Bariatric Surgery | • Coverage provided outside the United States. For full details, refer to your <u>plan</u> document. | • Private-duty nursing |
| • Chiropractic Care | • Hearing aids | • Routine foot care (for diabetics only) |
| | • Infertility treatment. \$20,000 lifetime maximum | • 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: North Dakota Insurance Department at 1-800-247-0560. 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 1-800-499-3416 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 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 <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,300
<i>What isn't covered</i>	
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 <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$600
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$2,620

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The <u>plan's</u> overall <u>deductible</u>	\$2,000
■ <u>Specialist</u> <u>coinsurance</u>	20%
■ Hospital (facility) <u>coinsurance</u>	20%
■ Other <u>coinsurance</u>	20%

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:	
<i>Cost Sharing</i>	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$2,200

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

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

Amharic - ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም
እርዳታ ድርጅቶቻችን ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም
እርዳታ ድርጅቶቻችን በነፃ ሊያገለግሉት 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 - ဟံသာဝတီသား- နမ့်ကတိၤ ကညိ ကျိာ်အသိ, နမၤန့ၢ် ကျိာ်အတၢ်မၤတၢ်လၢ
တၢ်လၢာ်တၢ်လၢာ်စ့ၤ နီတမံၤတၢ်သ့န့ၢ်လီၤ. 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. ໂທ (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: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือ
ทางภาษาได้ 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).