

 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://www.ndpers.nd.gov/sites/www/files/documents/members-additional-information/all-health/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 <b>haven't</b> 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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <u>deductibles</u> for specific services?	No.	You <b>don't</b> 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> <b>doesn't</b> cover.	Even though you pay these expenses, they <b>don't</b> count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See <a href="http://www.sanfordhealthplan.com">www.sanfordhealthplan.com</a> 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 <b>plan's</b> 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 <b>provider's</b> 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
		PPO Plan	Basic Plan	
If you visit a health care <b>provider's</b> 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 <b>aren't</b> <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 <a href="http://sanfordhealthplan.com/pharmacy">sanfordhealthplan.com/pharmacy</a>	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.
	Non-Formulary Drugs	50% <u>coinsurance</u> after <u>deductible</u>	50% <u>coinsurance</u> after <u>deductible</u>	Certain medications are limited to a 30-day supply, including but not limited to Specialty drugs and GLP-1 medications for diabetic diagnosis.  Insulin and medical supplies for insulin dosing and administration maximum \$25 cost-share 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%.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		PPO Plan	Basic Plan	
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>	
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>	

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>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.
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	<b>Children's</b> eye exam	Not covered	Not covered	None
	<b>Children's</b> glasses	Not covered	Not covered	None
	<b>Children's</b> 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.)

- |  |  |   |
|--|--|---|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Cosmetic surgery</li></ul> | <ul style="list-style-type: none"><li>• Dental care (Adult)</li><li>• Long-term care</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Weight loss programs</li></ul> |
|--|--|---|

### Other Covered Services (Limitations may apply to these services. This **isn't** a complete list. Please see your plan document.)

- |   |  |  |
|---|--|--|
| <ul style="list-style-type: none"><li>• Bariatric Surgery</li><li>• Chiropractic Care</li></ul> | <ul style="list-style-type: none"><li>• Coverage provided outside the United States. For full details, refer to your <u>plan</u> document.</li><li>• Hearing aids</li><li>• Infertility treatment. \$20,000 lifetime maximum</li></ul> | <ul style="list-style-type: none"><li>• Private-duty nursing</li><li>• Routine foot care (for diabetics only)</li><li>• Telehealth / e-visits / video visits</li></ul> |
|---|--|--|

**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](http://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](http://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 plan's overall deductible \$2,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 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:	

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$1,300
What <i>isn't</i> 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 coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 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:	

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$600
What <i>isn't</i> covered	
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 plan's overall deductible \$2,000
- Specialist coinsurance 20%
- Hospital (facility) coinsurance 20%
- Other coinsurance 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:	

Cost Sharing	
<u>Deductibles</u>	\$2,000
<u>Copayments</u>	\$0
<u>Coinsurance</u>	\$200
What <i>isn't</i> covered	
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.

