SANFORD HEALTH PLAN

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

Three Affiliated Tribes (Comprehensive Benefit Plan) self-funded **Coverage Period: 01/01/2023 – 12/31/2023**

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, **https://member.sanfordhealthplan.org/portal** or by calling **1-877-701-0792** | 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 **http://www.healthcare.gov/sbc-glossary** or call **1-877-701-0792** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For Network Providers **$0** Individual / **$0** Family For Out-Of-Network Providers **$0** Individual / **$0** Family Doesn't apply to preventive care or prescription drugs. Copays and coinsurance do not apply to the 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 annual maximum for this plan?	For Network Providers **$3,000** Individual / **$6,000** Family For Out-of-Network Providers **$3,000** Individual / **$6,000** 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 maximum?	Premiums, balance-billing charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out–of–pocket limit.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

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	Out-Of-Network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay / visit	$20 copay / visit	None.
	Chiropractic visit	$50 copay / visit	$50 copay / visit	Chiropractor visits include manual manipulation of the spine and extremities and therapy and diagnostic services. 30 visits, additional visits if medically necessary with PA
	Specialist visit	$50 copay / visit	$50 copay / visit	None.
	Preventive care/screening/ immunization	No charge	No charge	You may have to pay for services that are not preventive. Ask your provider if the services you need are preventive, then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	20% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	20% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at sanfordhealthplan.com/pharmacy	Tier 1 — Generic drugs	$0 copay for 1-90 day supply	$0 copay for 1-90 day supply	Covers 30-day supply up to 90-day supply by either retail or mail order pharmacy. Substance abuse medications are covered at $0 copay Refer to your Formulary to determine which benefit applies to your medication.
	Tier 2 — Preferred (Formulary) brand drugs	$20 copay for 1-30 day supply $40 copay for 31-90 day supply	$20 copay for 1-30 day supply $40 copay for 31-90 day supply	
	Tier 3 — Non-preferred (Non-Formulary) brand drugs	$50 copay for 1-30 day supply $100 copay for 31-90 day supply	$50 copay for 1-30 day supply $100 copay for 31-90 day supply	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-Of-Network Provider	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$250 copay, then 20% coinsurance	$250 copay, then 20% coinsurance	Prior authorization required
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need immediate medical attention	Emergency room care	$200 copay / visit, then 20% coinsurance	$200 copay / visit, then 20% coinsurance	Emergency room copay waived if directly admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$50 copay	$50 copay	
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay, then 20% coinsurance	$250 copay, then 20% coinsurance	Not covered
	Physician/surgeon fees	20% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No Charge	No Charge with Prior Authorization	Prior authorization required. Prior authorization for all SUD Services must obtained through MHA Recovery at (701) 421-8869. Intensive Outpatient Program for Substance Use Disorder and partial Hospitalization Program for Substance Use Disorder require Prior authorization.
	Inpatient services	No Charge with Prior Authorization	No Charge with Prior Authorization	Prior authorization required. Prior authorization for all SUD Services must be obtained through MHA Recovery at (701) 421-8869.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider	Out-Of-Network Provider	
If you are pregnant	Office visits	No charge	No charge	Cost sharing does not apply to routine prenatal and postnatal-care and certain preventive services. Depending on the type of services, copayment / coinsurance may apply.
	Childbirth/delivery professional services	20% coinsurance	20% coinsurance	
If you are pregnant	Childbirth/delivery facility services	20% coinsurance	20% coinsurance	Maternity care may include tests and services (i.e. ultrasound).
If you need help	Home health care	20% coinsurance	20% coinsurance	40 visits, additional visits if medically necessary with PA
recovering or have other special health needs	Physical Therapy/Occupational Therapy	20% coinsurance	20% coinsurance	30 visits, additional visits if medically necessary with PA
	Speech Therapy	20% coinsurance	20% coinsurance	45 visits, Prior authorization required
	Skilled nursing care	$250 copay / visit, then 20% coinsurance	$250 copay / visit, then 20% coinsurance	Prior authorization required. Limited to 70 visits per calendar year.
	Durable medical equipment	20% coinsurance	20% coinsurance	Prior authorization required
	Hospice services	$250 copay / visit, then 20% coinsurance 20% coinsurance	$250 copay / visit, then 20% coinsurance 20% coinsurance	Inpatient Services Outpatient Services
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.)		
• Cosmetic surgery	• Pediatric dental & vision care	• Routine foot care
• Long-term care	• Routine dental services (adult)	• Weight loss programs
	• Routine eye care (adult)	

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture-20 visits, additional if mdically necessary with PA	• Hearing aids—20% coinsurance; 1 per year, each ear for Members under age 18 and 1 every-other year over age 18	• Travel vaccines
• Weight loss surgery—based on medical necessity with Tribal Council Approval.		• Orthotic Devices due to complications of Diabetes
• Chiropractic Care		• Infertility diagnostic services—$250 copay; 20% coinsurance for hospital

Your Rights to Continue Coverage: 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. 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 at 1-800-752-5863.

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 pre-natal care and a hospital delivery)

The plan's overall deductible	$0
Specialist copayment	$50
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	
Deductibles	$0
Copayments	$0
Coinsurance	$2,528
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,588**

Managing Joe's type 2 Diabetes
(a year of routine care of a well-cont rolled condition)

The plan's overall deductible	$0
Specialist copayment	$50
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	
Deductibles*	$0
Copayments	$500
Coinsurance	$1020
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,540**

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

The plan's overall deductible	$0
Specialist copayment	$50
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	
Deductibles*	$0
Copayments	$600
Coinsurance	$440
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1,040**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: Sanford Wellness at 1-877-305-5463.
*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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 Sanford Health Plan at (800) 752-5863 | TTY: 711.

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 the Civil Rights Coordinator at 300 Cherapa Place #201, Sioux Falls, SD 57103, call (800) 325-9402 | TTY: 711, fax (605) 328-6812, or e-mail compliancehotline@sanfordhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Civil Rights Coordinator is available to help you.

You can also file a civil rights complaint with the US 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: US Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, (800) 368-1019, TTY/TDD (800) 537-7697. Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

Free help in other languages

For help in any language other than English, please call **1-800-752-5863** | TTY: 711.

If you have any questions, for example, about your benefits, a document, or how Sanford Health Plan pays for your care, please call us.

Spanish: Si usted, o alguien a quien usted está ayudando, tiene preguntas acerca de Sanford Health Plan, tiene derecho a obtener ayuda e información en su idioma sin costo alguno. Para hablar con un intérprete, llame al 1-844-927-2969.

Hmong: Yog koj, los yog tej tus neeg uas koj pab ntawd, muaj lus nug txog Sanford Health Plan, koj muaj cai kom lawv muab cov ntshiab lus qhia uas tau muab sau ua koj hom lus pub dawb rau koj. Yog koj xav nrog ib tug neeg txhais lus tham, hu rau 1-844-923-3519.

Cushite: Isin yookan namni biraa isin deeggartan Sanford Health Plan irratti gaaffii yo qabaattan, kaffaltii irraa bilisa haala ta'een afaan keessaniin odeeffannoo argachuu fi deeggarsa argachuuf mirga ni qabdu. Nama isiniif ibsu argachuuf, lakkoofsa bilbilaa 1-844-927-2968 tiin bilbilaa.

Vietnamese: Nếu quý vị, hay người mà quý vị đang giúp đỡ, có câu hỏi về Sanford Health Plan, quý vị sẽ có quyền được giúp và có thêm thông tin bằng ngôn ngữ của mình hoàn toàn miễn phí. Để nói chuyện với một thông dịch viên, xin gọi 1-844-927-2973.

Chinese (Mandarin): 如果您，或您正在幫助的人，有關於Sanford Health Plan 方面的問題，您有權利免費以您的母語得到幫助和訊息。想要跟一位翻譯員通話，請致電 1-844-923-3524。

German: Falls Sie oder jemand, dem Sie helfen, Fragen zum Sanford Health Plan haben, haben Sie das Recht, kostenlose Hilfe und Informationen in Ihrer Sprache zu erhalten. Um mit einem Dolmetscher zu sprechen, rufen Sie bitte die Nummer 1-844-923-3517 an.

Russian: Если у вас или лица, которому вы помогаете, имеются вопросы по поводу Sanford Health Plan, то вы имеете право на бесплатное получение помощи и информации на вашем языке. Для разговора с переводчиком позвоните по телефону 1-844-927-2967.

Laotian: ຖ້າທ່ານ, ຫ ຼ ຼືຄົນທ ່ີ ທ່ານກໍ າລັ ງຊ່ວຍເຫ ຼ ຼືອ, ມ ່ີຄໍາຖາມກ່ຽວກັ ບ Sanford Health Plan, ທ່ານມ ີສິດທ ່ີ ຈະໄດ້ຮັບການຊ່ວຍເຫ ຼ ຼືອແລະຂໍ້ ມູ ນຂ່າວສານທ ່ີ ເປັ ນພາສາຂອງທ່ານບໍ່ ມ ີຄ່າໃຊ້ຈ່າຍ. ການໂອ້ລົ ມກັ ບນາຍພາສາ, ໃຫ້ໂທຫາ 1-800-752-5863.

Arabic:

إن كان لديك أو لدى شخص تساعده أسئلة بخصوص Sanford Health Plan ، فلديك الحق في الحصول على المساعدة والمعلومات الضرورية بلغتك من دون اية تكلفة. للتحدث مع مترجم اتصل ب 1-844-923-3511.

Karen:

တၢ်ကွဲးနီၣ်အဝဲအံၤန့ၣ်အိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢအရှၢ်ၣ်တဖၣ်န့ၣ်လီၤ.တၢ်ကွဲးနီၣ်အဝဲအံၤအိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢအရှၢ်ၣ်ဘၣ်ဃးဒီးနလၢ်ပတံထိၣ်မ့တမ့ၢ်တၢ်ကျၢၢ်ဘၢခီဖျိ Sanford Health Plan န့ၣ်လီၤ.ယုကွၢ်မ့ၢ်နံၤမုၢ်သီအခိၣ်သ့ၣ်လၢတၢ်ကွဲးနီၣ်အံၤတက့ၢ်.ဘၣ်သ့ၣ်သ့ၣ်နကဘၣ်ဟံးန့ၢ်မူဒါလၢမုၢ်နံၤမုၢ်သီလၢတၢ်ဆၢတဲာ်ယာ်လၢနကဟ်ယာ်နတၢ်အိၣ်ဆူၣ်အိၣ်ချ့တၣ်ကျၢၣ်ဘၢမ့တမ့ၢ်တၢ်မၤစၢၤလၢနကဘၣ်ဟ့ၣ်အပွၤန့ၣ်လီၤ.နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒၣ်နဲလၢတလိၣ်ဟ့ၣ်အပွၤဘၣ်န့ၣ်လီၤ.ကိး 1-844-923-3522 တက့ၢ်.

Amharic:

እርስዎ፣ ወይም እርስዎ የሚያግዙት ግለሰብ፣ ስለ Sanford Health Plan ያለ ምንም ክፍያ በቋንቋዎ እርዳታና መረጃ የማግኘት መብት አላችሁ። ከአስተርጓሚ ጋር ለመነጋገር፣ ይደውሉ። 1-800-752-5863

Korean: 만약 귀하 또는 귀하가 돕고 있는 어떤 사람이 Sanford Health Plan 에 관해서 질문이 있다면 귀하는 그러한 도움과 정보를 귀하의 언어로 비용 부담없이 얻을 수 있는 권리가 있습니다. 그렇게 통역사와 얘기하기 위해서는 1-844-923-3523로 오.

French: Si vous, ou quelqu'un que vous êtes en train d'aider, a des questions à propos de Sanford Health Plan, vous avez le droit d'obtenir de l'aide et l'information dans votre langue à aucun coût. Pour parler à un interprète, appelez 1-844-923-3516.

Serbo-Croatian: Ukoliko Vi ili neko kome Vi pomažete ima pitanje o Sanford Health Plan, imate pravo da besplatno dobijete pomoć i informacije na Vašem jeziku. Da biste razgovarali sa prevodiocem, nazovite 1-800-752-5863.

Cambodian, Mon-Khmer: ប្រសិនបើអ្នក ឬនរណាម្នាក់ដែលអ្នកកំពុងជួយ មានសំណួរអំពី Sanford Health Plan អ្នកមានសិទ្ធិទទួលជំនួយនិងព័ត៌មាន ជាភាសារបស់អ្នក ដោយមិនអស់លុយ។ ដើម្បីនិយាយជាមួយអ្នកបកប្រែ សូម 1-844-923-3512។

Bantu: Nimba wewe canke umuntu uriko urafasha afise ibibazo vyerekeye Sanford Health Plan, utegerezwa kugira uburenganzira bwo kuronka ubufasha n'amakuru arambuye mu rurimi gwawe ataco utanze canke kurihira.
Hamagara 1-800-752-5863 uhamagara umusobanuzi.

Swahili: Kama wewe, au mtu unaye mpa usaidizi ana maswali kuhusu Sanford Health Plan, Una haki ya kupata habari hii na msaada kwa lugha yako bila gharama. Kuzungumza na mkalimani, piga nambari hii: 1-844-927-2970.

Japanese: ご本人様、またはお客様の身の回りの方でも、Sanford Health Plan についてご質問がございましたら、ご希望の言語でサポートを受けたり、情報を入手したりすることができます。料金はかかりません。通訳とお話される場合、1-844-923-3521 までお電話ください。

Tagalog: Kung ikaw, o ang iyong tinutulangan, ay may mga katanungan tungkol sa Sanford Health Plan, may karapatan ka na makakuha ng tulong at impormasyon sa iyong wika ng walang gastos. Upang makausap ang isang tagasalin, tumawag sa 1-800-752-5863.

Nepali: यदि तपाईं आफ्ना लादि आफैं आवेदिनको काम गरिरहनुभएको, वा कसलाई मद्दत गरिरहनुहुन्छ, Sanford Health Plan बारे प्रश्नहरू छन् भने आफ्नो मातृभाषामा दिइने निःशुल्क सहायता वा जानकारी पाउने अदिकार छ। दोभाषे (इन्टरप्रेटर) सँग कुरा गर्नु परे 1-844-927-2961 मा फोन गर्नुहोस्।

Norwegian: Hvis du, eller noen du hjelper, har spørsmål om Sanford Health Plan, har du rett til å få hjelp og informasjon på ditt språk uten kostnad. For å snakke med en tolk, ring 1-800-752-5863.

Help understanding your health insurance is free.

If you would like something 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: 711

North Dakota Medicaid Expansion:
Please call (855) 305-5060 (toll-free) | TTY: 711