SANFORD HEALTH PLAN

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

Lewis Drug, Inc. $4,000 | South Dakota

Coverage Period: 1/1/18 to 12/31/18

Coverage for: Individual + Family | Plan Type: HMO | 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, go to sanfordhealthplan.com/policy/SVHP-0077.pdf or call 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 www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf or call 1-800-752-5863 to request a copy.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For network providers $4,000 individual / $8,000 family. For out-of-network providers $6,000 individual / $12,000 family.	Generally, you must pay all the costs from the 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 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 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 $6,000 individual / $12,000 family. For out-of-network providers $9,000 individual / $18,000 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 limit?	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.
Will you pay less if you use a network provider?	Yes. See www.sanfordhealthplan.org or call 1-800-752-5863 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's 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.

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 provider's office or clinic	Primary care visit to treat an injury or illness	$30 copay / visit; Deductible does not apply	40% coinsurance	None
	Specialist visit	$30 copay / visit; Deductible does not apply	40% coinsurance	None
	Preventive care / screening / Immunization	No charge	40% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services you need are preventive. For details reference the Preventive Health Guidelines or contact Customer Service.
If you have a test	Diagnostic test (x-ray, blood work)	20% coinsurance	40% coinsurance	None
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sanfordhealthplan.org	Generic drugs (Tier 1)	$15 copay / prescription; Deductible does not apply	Not Covered	Covers up to a 30 day supply. Some specialty medications may be obtained with a copay depending on where they are received or administered. Refer to your Summary of Pharmacy Benefits / Formulary to determine which benefit applies to your medication. Certain contraceptive drugs covered at 100%.
	Preferred brand drugs (Tier 2)	$35 copay / prescription; Deductible does not apply	Not Covered	
	Non-preferred brand drugs (Tier 3)	$50 copay / prescription; Deductible does not apply	Not Covered	
	Specialty drugs	20% coinsurance	Not Covered	

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 outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	These services require certification by the plan for in-network coverage levels to apply.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need immediate medical attention	Emergency room care	$150 copay / visit; Deductible does not apply	$150 copay / visit; Deductible does not apply	Copay waived if directly admitted. Out-of-network is the same as in-network benefit unless the plan determines the condition did not meet prudent layperson definition of emergency; then the out-of-network deductible and coinsurance applies. Member is responsible for charges above Reasonable Cost of defined by the Policy/Certificate of Insurance.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$30 copay / visit; Deductible does not apply	$30 copay / visit; Deductible does not apply	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply.
	Physician/surgeon fees	20% coinsurance	40% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$30 copay / visit; Deductible does not apply and 20% coinsurance for other outpatient services	40% coinsurance	None
	Inpatient services	20% coinsurance	40% coinsurance	Inpatient services require certification by the Health Plan for in-network coverage levels to apply. For full details, please refer to your policy.
If you are pregnant	Office visits	$30 copay / visit; Deductible does not apply and 20% coinsurance for other outpatient services	40% coinsurance	Cost sharing does not apply for 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	20% coinsurance	40% coinsurance	
	Childbirth/delivery facility services	20% coinsurance	40% 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 need help recovering or have other special health needs	Home health care	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. Limited to 40 visits per calendar year.
	Rehabilitation services	$30 copay / visit; Deductible does not apply and 20% coinsurance for ancillary services	40% coinsurance	Office Visit includes practitioner consults. Ancillary includes but is not limited to x-rays, labs, ultrasounds, and rehabilitation therapy. Limited to 30 visits per therapy per calendar year.
	Habilitation services	Not Covered	Not Covered	None
	Skilled nursing care	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. Limited to 30 days in any consecutive 12-month period.
	Durable medical equipment	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply. For full details, please refer to your Policy/Certificate of Insurance.
	Hospice services	20% coinsurance	40% coinsurance	These services require certification by the Health Plan for in-network coverage levels to apply.
If your child needs dental or eye care	Children's eye exam	No Charge	40% coinsurance	Covered when part of a preventive exam.
	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	• Infertility treatment	• Private Duty Nursing
• Cosmetic Surgery	• Long-term care	• Routine eye care (Adult)
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	• Weight loss programs
• Hearing Aids		

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Bariatric Surgery	• Routine foot care (for diabetics only)	• Telehealth/e-visit/video visit services
• Chiropractic Care		

Your Right to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for these 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 grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact: Sanford Health Plan/Customer Service 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 the 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 1-855-857-4426 (toll free).
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-855-857-4426 (toll free).
Chinese (中文): 如果需要中文的帮助,请拨打这个号码 1-855-857-4426 (toll free).
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-855-857-4426 (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 $4,000
- Specialist copayment $30
- 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	$4,000
Copayments	$40
Coinsurance	$1,000
What isn't covered	
Limits Or Exclusions	$60
The Total Peg Would Pay Is	$5,100

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

- The plan's overall deductible $4,000
- Specialist copayment $30
- 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	$7,400

In this example, Joe would pay:

Cost Sharing	
Deductibles*	$100
Copayments	$1,600
Coinsurance	$0
What isn't covered	
Limits Or Exclusions	$60
The Total Joe Would Pay Is	$1,760

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

- The plan's overall deductible $4,000
- Specialist copayment $30
- Hospital (facility) coinsurance 20%
- Other coinsurance 20%

This EXAMPLE event includes services like:
Emergency room care (including medical supplies)
Diagnostic tests (x-ray)
Durable medical equipment (crutches)
Rehabilitation services (physical therapy)

Total Example Cost	$1,930

In this example, Mia would pay:

Cost Sharing	
Deductibles*	$1,400
Copayments	$200
Coinsurance	$0
What isn't covered	
Limits Or Exclusions	$0
The Total Mia Would Pay Is	$1,600

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 and 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 and information written in other languages.

If you need these services, contact Sanford Health Plan at 1-800-752-5863, 8 a.m. to 5 p.m. Central Time, Monday-Friday.

If you believe Sanford Health Plan has failed to provide these services or discriminated in any way. Contact our Director of Customer Service and Enrollment, 300 Cherapa Place #201, Sioux Falls, SD 57103, 1-605-328-6800, TTY Number 1-877-652-1844, memberservices@sanfordhealth.org. You can file a grievance in person or by mail, fax, or email.

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, 1-800-368-1019, TDD Number: 1-800-537-7697.Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

Free help in other languages

For help in a language other than English, please call us toll-free at 1-800-892-0675. 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 1-855-857-4426 (TTY: 1-877-652-1844).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-855-857-4426 (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 1-855-857-4426 (TTY: 1-877-652-1844).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-855-857-4426 (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 1-855-857-4426 (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 1-855-857-4426 (TTY: 1-877-652-1844).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-855-857-4426 (TTY: 1-877-652-1844).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-855-857-4426 (телетайп: 1-877-652-1844)

Laotian: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-855-857-4426 (TTY: 1-877-652-1844).

Arabic: ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية المتوافرة بالمجان لك. اتصل برقم 1-778-256-4481 (رقم هاتف الصم والبكم 1-855-758-6244)

Karen:

တၢ်ကွဲးနီၣ်အဝဲအံၤန့ၣ်အိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢအရှနီၣ်တဖၣ်နူၣ်လီၤ.တၢ်ကွဲးနီၣ်အဝဲအံၤအိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤ
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နူၣ်လီၤ.ယုကွၢ်မုၢ်နံၤမုၢ်သီအခီၣ်သ့ၣ်လၢတၢ်ကွဲးနီၣ်အံၤတက့ၢ်.ဘၣ်သ့ၣ်သ့ၣ်နကဘၣ်ဟံးန့ၢ်မူးဒါလၢမုၢ်နံၤမု
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ပူၤန့ၣ်လီၤ.နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒၣ်နဲလၢတလိၣ်ဟ့ၣ်အ
ပူၤဘၣ်န့ၣ်လီၤ.ကိး 1-800-892-0675 တက့ၢ်.

Amharic: ማስ; 1-855-857-4426 ት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-855-857-4426 (መስማት ለተሳናቸው: 1-877-652-1844).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-855-857-4426 (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 1-855-857-4426 (ATS: 1-877-652-1844).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-855-857-4426 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-877-652-1844).

Cambodian, Mon-Khmer:

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ

1-855-857-4426 (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: 1-800-752-5863 (toll-free) | TTY/TDD: 1-877-652-1844