SANFORD HEALTH PLAN

North Dakota Public Employees Retirement System Grandfathered Dakota Plan

Coverage Period: 07/01/15 – 06/30/17
Coverage for: Single, Family

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Plan Type: PPO | Grandfathered

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy at www.sanfordhealthplan.com/ndpers or by calling **1-800-499-3416** *(toll-free)* | TTY/TDD: **1-877-652-1844** *(toll-free)*.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	For in-network providers: **$400** person / **$1,200** family For out-of-network providers: **$400** person / **$1,200** family Doesn't apply to preventive care or prescription drugs. Copays and coinsurance do not apply to the deductible.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	Yes. **$500** for infertility services. There are no other specific **deductibles**.	You must pay all of the costs for these services up to the specific **deductible** amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	For in-network providers: **$1,150** person / **$2,700** family For out-of-network providers: **$1,650** person / **$3,700** family	The **out-of-pocket limit** is the most you could pay during a coverage period (annually/usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premiums, balance-billed charges, infertility services, copayments, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. See **www.sanfordhealthplan.com/ndpers or call 1-800-499-3416** *(toll-free)* for a list of participating providers.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or **participating** for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a **participating** specialist.	You can see the **participating specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 4. See your policy for additional information about **excluded services**.

Questions: Call 1-800-499-3416 *(toll-free)* or visit us at **www.sanfordhealthplan.com/ndpers.** If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at **www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call 1-800-499-3416 to request a copy.

North Dakota Public Employees Retirement System

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- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the Plan's **allowed amount** for an overnight hospital stay is $1,000; your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000; you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **participating providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use Basic Plan After Deductible	Your cost if you use PPO Plan After Deductible	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care to treat an injury or illness	$30 copay/visit	$25 copay/visit	Deductible is waived.
	Chiropractic care			Deductible is waived.
	Office visit	$30 copay/visit	$25 copay/visit	Includes chiropractic consult and manual manipulations.
	Ancillary services	25% coinsurance	20% coinsurance	Includes but not limited to x-rays, labs, ultrasounds and rehabilitative therapy.
	Specialist visit	$30 copay/visit	$25 copay/visit	Deductible is waived.
	Other practitioner office visit	$30 copay/visit	$25 copay/visit	Deductible is waived.
	Preventive care/screening	$30 copay/related office visit. No charge for other services.	$25 copay/related office visit. No charge for other services.	Deductible is waived. 25% coinsurance for prostate cancer screening out-of-network and 20% coinsurance for prostate cancer screening in-network.
	Immunizations	No charge	No charge	
If you have a test	Diagnostic test (x-ray, blood work)	25% coinsurance	20% coinsurance	——none——
	Imaging (CT/PET scans, MRIs)	25% coinsurance	20% coinsurance	——none——

Common Medical Event	Services You May Need	Your cost if you use Basic Plan After Deductible	Your cost if you use PPO Plan After Deductible	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at sanfordhealthplan.com/ndpers	Generic Formulary Drugs	$5 copay/ prescription, then 15% coinsurance	$5 copay/ prescription; then 15% coinsurance	Covers up to a 34 day supply. Two copays for a 35-100 day supply. $1,000 coinsurance maximum per person per benefit period. Refer to your Formulary to determine which benefit applies to your medication.
	Brand Name Formulary Drugs	$20 copay/ prescription, then 25% coinsurance	$20 copay/ prescription; then 25% coinsurance	
	Non-Formulary Drugs	$25 copay/ prescription, then 50% coinsurance	$25 copay/ prescription; then 50% coinsurance	Covers up to a 34 day supply. Two copays for a 35-100 day supply.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan.
	Physician/surgeon fees	25% coinsurance	20% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$50 copay/visit, then 20% coinsurance	$50 copay/visit, then 20% coinsurance	Copay waived if directly admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	
	Urgent care	$25 copay/visit	$25 copay/visit	Deductible is waived.
If you have a hospital stay	Facility fee (e.g., hospital room)	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan.
	Physician/surgeon fee	25% coinsurance	20% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your cost if you use Basic Plan After Deductible	Your cost if you use PPO Plan After Deductible	Limitations & Exceptions
If you have mental/behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services Office visit All other services	 $30 copay/visit 20% coinsurance	 $25 copay/visit 20% coinsurance	For outpatient treatment services, the first five (5) hours in a calendar year will be covered at 100% (no charge). For full details, please refer to your Policy.
	Mental/Behavioral health inpatient services	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan. For full details, please refer to your Policy.
	Substance use disorder outpatient services Office visit All other services	 $30 copay/visit 20% coinsurance	 $25 copay/visit 20% coinsurance	For outpatient treatment services, the first five (5) visits in a calendar year will be covered at 100% (no charge). For full details, please refer to your Policy.
	Substance use disorder inpatient services	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan. For full details, please refer to your Policy.
If you are pregnant	Prenatal and postnatal care	25% coinsurance	20% coinsurance	Deductible is waived.
	Delivery and all inpatient services	25% coinsurance	20% coinsurance	Deductible is waived for delivery services received from a PPO health care provider when a Member is enrolled in the Healthy Pregnancy Program.
If you need help recovering or have other special health needs	Home health care	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan.
	Rehabilitation services	$25 copay/visit, then 25% coinsurance	$20 copay/visit, then 20% coinsurance	Deductible is waived.
	Habilitation services	$25 copay/visit, then 25% coinsurance	$20 copay/visit, then 20% coinsurance	Deductible is waived.

Common Medical Event	Services You May Need	Your cost if you use Basic Plan After Deductible	Your cost if you use PPO Plan After Deductible	Limitations & Exceptions
If you need help recovering or have other special health needs (continued)	Skilled nursing care	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan.
	Durable medical equipment	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan.
	Hospice service	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan.
If your child needs dental or eye care	Routine eye exam	Not covered	Not covered	——none——
	Glasses	Not covered	Not covered	——none——
	Routine dental check-up	Not covered	Not covered	——none——

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture • Cosmetic surgery • Dental care (Adult)	• Hearing aids (unless for Members under age 18) • Long-term care	• Pediatric dental and vision care • Routine eye care (Adult) • Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery • Chiropractic care	• Coverage provided outside the United States. For full details, please refer to your Policy or see www.sanfordhealth.com/ndpers • Infertility treatment; $20,000 lifetime maximum	• Private-duty nursing • Routine foot care (for diabetics only)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your right to continue coverage may also apply.

For more information on your rights to continue coverage, contact the Plan toll-free at (800) 499-3416. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at (877) 267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your Plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact:

- Sanford Health Plan/Member Services toll-free at (800) 499-3416
- The U.S. Department of Labor, Employee Benefits Security Administration at (866) 444-3272 *(toll-free)* or www.dol.gov/ebsa
- North Dakota Insurance Department at (800) 247-0560 *(toll-free)* or www.nd.gov/ndins/contact

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

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 page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $6,200
- **Patient pays** $1,340

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Copays	$10
Coinsurance	$1,300
Limits or exclusions	$30
Total	**$1,340**

Note: These numbers assume the patient has enrolled in the Plan's Health Pregnancy Program. If you are pregnant, and have not given notice of your pregnancy to the Plan, your costs may be higher. For more information, please contact Sanford Health Plan at 1-888-315-0885 *(toll-free)* | TTY/TDD: 1-877-652-1844 *(toll-free)*.

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,520
- **Patient pays** $880

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$400
Copays	$400
Coinsurance	$0
Limits or exclusions	$80
Total	**$880**

Note: These examples do not reflect cost sharing for any Consumer Driven Health Plan such as HRA, HSA, FSA or any wellness program.

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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