SANFORD HEALTH PLAN

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

North Dakota Public Employees Retirement System Grandfathered Dakota Plan **Coverage Period: 07/01/2017-06/30/2019**

Coverage for: Single, Family | **Plan Type:** PPO | 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, **http://www.nd.gov/ndpers/insurance-plans/docs/sanford-health/shp-coi-gf.pdf** or by calling **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 **http://www.dol.gov/ebsa/pdf/SBCUniformGlossary.pdf** or call **1-800-499-5863** to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	For network providers **$500** individual / **$1,500** family. For out-of-network providers **$500** individual / **$1,500** family.	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?	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.
What is the out-of-pocket limit for this plan?	For network providers **$1,500** individual / **$3,500** family. For out-of-network providers **$2,000** individual / **$4,500** 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, infertility, copays, 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.com** 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
		Basic Plan After Deductible	PPO Plan After Deductible	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$35 copay/visit; deductible does not apply	$30 copay/visit; deductible does not apply	None
	Specialist visit	$35 copay/visit; deductible does not apply	$30 copay/visit; deductible does not apply	None
	Preventive care/screening/ immunization	$35 copay/visit; deductible does not apply. No charge for other services.	$30 copay/visit; deductible does not apply. No charge for other services.	Deductible is waived. 25% coinsurance for prostate cancer screening out-of-network and 20% coinsurance for prostate screening in-network.
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
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at sanfordhealthplan.com	Generic Formulary Drugs	$7.50 copay /prescription (0-34 days) & $15 copay /prescription (35-100 days) deductible does not apply; then 12% coinsurance.	$7.50 copay /prescription (0-34 days) & $15 copay /prescription (35-100 days) deductible does not apply; then 12% 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	$25 copay /prescription (0-34 days) & $50 copay /prescription (35-100 days) deductible does not apply; then 25% coinsurance.	$25 copay /prescription (0-34 days) & $50 copay /prescription (35-100 days) deductible does not apply; then 25% coinsurance.	
	Non-Formulary Drugs	$30 copay /prescription (0-34 days) & $60 copay /prescription (35-100 days) deductible does not apply; then 50% coinsurance.	$30 copay /prescription (0-34 days) & $60 copay /prescription (35-100 days) deductible does not apply; 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

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Basic Plan After Deductible	PPO Plan After Deductible	
If you need immediate medical attention	Emergency room care	$60 copay/visit; deductible does not apply; then 20% coinsurance	$60 copay/visit; deductible does not apply; then 20% coinsurance	Emergency Room copay waived if directly admitted.
	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)	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan. For full details, please refer to your Policy.
	Physician/surgeon fees	25% coinsurance	20% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/office visit; deductible does not apply and 20% coinsurance for other outpatient services	$30 copay/office visit; deductible does not apply and 20% coinsurance for other outpatient services	For outpatient treatment services, the first 5 visits of any calendar year will be covered at 100% (no charge). For full details, please refer to your Policy.
	Inpatient services	25% coinsurance	20% 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	$35 copay/office visit; deductible does not apply and 25% coinsurance for other outpatient services	$30 copay/office visit; deductible does not apply and 20% coinsurance for other outpatient services	Deductible is waived for office visits and delivery services received from a PPO health care provider when a Member is enrolled in the Health Pregnancy Program.
	Childbirth/delivery professional services	25% coinsurance	20% coinsurance	
	Childbirth/delivery facility services	25% coinsurance	20% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Basic Plan After Deductible	PPO Plan After Deductible	
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	$30 copay/office visit; deductible does not apply and 25% coinsurance for other outpatient services	$25 copay/office visit; deductible does not apply and 20% coinsurance for other	None
	Habilitation services	$30 copay/office visit; deductible does not apply and 25% coinsurance for other outpatient services	$25 copay/office visit; deductible does not apply and 20% coinsurance for other outpatient services	None
	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 services	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan.
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	• Hearing aid (unless under age 18)	• Non-emergency care when traveling outside the U.S.
• Cosmetic surgery	• Long-term care	• Routine eye care (Adult)
• Dental care (Adult)		• 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, please refer to your Policy or see www.sanfordhealth.com/ndpers	• Private-duty nursing
• Chiropractic Care	• Infertility treatment; $20,000 lifetime maximum	• Routine foot care (for diabetics only)
		• 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/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 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 in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	$500
■ Specialist copayment	$35
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	$500
Copayments	$0
Coinsurance	$1,500
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,060**

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

■ The plan's overall deductible	$500
■ Specialist copayment	$35
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	$1,300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Joe would pay is	**$1,460**

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

■ The plan's overall deductible	$500
■ Specialist copayment	$35
■ Hospital (facility) coinsurance	25%
■ Other coinsurance	25%

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	**$1,930**
In this example, Mia would pay:	
Cost Sharing	
Deductibles*	$500
Copayments	$200
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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 our Civil Rights Coordinator.

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 our Director of Member Services, 300 Cherapa Place #201, Sioux Falls, SD 57109, (605) 328-6800, TTY Number: (877) 652-1844, memberservices@sanfordhealth.org. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, our Civil Rights 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, DC 20201, 1-800-368-1019, 800-537-7697 (TDD).

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 (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 1-800-892-0675 (TTY: 1-877-652-1844).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-892-0675 (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 1-800-892-0675 (TTY: 1-877-652-1844).

Cushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-892-0675 (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 1-800-892-0675 (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 1-800-892-0675 (TTY: 1-877-652-1844). 。

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-892-0675 (TTY: 1-877-652-1844).

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-892-0675 (телетайп: 1-877-652-1844)

Laotian: ໂປດຊາບ: ຖ້ າວ່ າທ່ ານເ ວ້ າພາສາ ລາວ, ການ ໍບ ິລການຊ່ ວຍເຫຼ ືອດ້ ານພາສາ, ໂດຍ ່ ໍບເສັ ຽຄ່ າ,ແມ່ ນມີ ພ້ ອມໃຫ້ ທ່ ານ. ໂທຣ 1-800-892-0675 (TTY: 1-877-652-1844).

Arabic: ال لغوى ة ال م ساعدة خدمات ن إن ال ل غة، اذكر ن ىحدث ك نت إذا :م لحوظة 1-778-256-4481 (رق م
ر ىواى ن ك ل المجان ب. صل ان م رق ب 5760-298-008-1- ف هاى صم ال بكم ال وال

Karen:
တၢ်ကွဲးနီၣ်အဝဲအံၤန့ၣ်အိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢအရှ့ဒိၣ်တဖၣ်နှ့ၣ်လီၤ.တၢ်ကွဲးနီၣ်အဝဲအံၤအိၣ်ဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤ လၢအရှ့ဒိၣ်ဘၣ်ဃးဒီးနလံာ်ပတံထီၣ်မ့တမ့ၢ်တၢ်ကျၢ်ဘၢခီဖျိ Sanford Health Plan
နှ့ၣ်လီၤ.ယုကွၢ်မုၢ်နံၤမုၢ်သီအခိၣ်သ့ၣ်လၢတၢ်ကွဲးနီၣ်အံၤတကွၢ်.ဘၣ်သ့ၣ်သ့ၣ်နကဘၣ်ဟံးန့ၢ်မူဒါလၢမုၢ်နံၤမုၢ်သီလၢတၢ်ဆၢတဲာ်ဃာ်လၢနကဟ်ဃာ်နတၢ်အိၣ်ဆူၣ်အိၣ်ချ့တၣ်ကျၢၣ်ဘၢမ့တမ့ၢ်တၢ်မၤစၢၤလၢနကဘၣ်ဟ့ၣ်အပ့ၤနှ့ၣ်လီၤ.နအိၣ်ဒီးတၢ်ခွဲးတၢ်ယာ်လၢနကဒိးန့ၢ်ဘၣ်တၢ်မၤစၢၤဒီးတၢ်ဂ့ၢ်တၢ်ကျိၤလၢနကျိာ်ဒၣ်နဲလၢတလိၣ်ဟ့ၣ်အပ့ၤဘၣ်နှ့ၣ်လီၤ.ကိး 1-800-892-0675 တကွၢ်.

Amharic: ማስታወሻ: የሚናገሩት ቋንቋ ኣማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-800-892-0675 (መስማት ለተሳናቸው: 1-877-652-1844).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-892-0675 (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 1-800-892-0675 (ATS : 1-877-652-1844).

Serbo-Croatian: OBAVJEŠTENJE: Ako govorite srpsko-hrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-800-892-0675 (TTY- Telefon za osobe sa oštećenim govorom ili sluhom: 1-877-652-1844).

Cambodian, Mon-Khmer:
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ
1-800-892-0675 (TTY: 1-877-652-1844)

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