Summary of Benefits and Coverage 2016

SANFORD HEALTH

Administered by: SANFORD HEALTH PLAN

Sanford Health Gold

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

Coverage Period: 01/01/2016 – 12/31/2016
Coverage for: Individual + Family
Plan Type: HMO | Non-Grandfathered

This is only a summary. If you have questions about information in this summary, or want more detail about your coverage and costs, you can get the complete terms in the policy at **http://sanfordhealthplan.com/policy/hp-0584.pdf** or by calling **(800) 752-5863** *(toll-free)* | TTY/TDD: **(877) 652-1844** *(toll-free)*.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,250** person/**$2,500** family (in-network) Doesn't apply to preventive care. Out of network NOT COVERED	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?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$3,750** person/**$7,500** family (in-network) Out-of-network NOT COVERED	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, 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/memberlogin or call (800) 752-5863** 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 an in-network specialist.	You can see the in-network **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 6. Failure to obtain prior authorization may result in a denial of claims and the member will be required to pay for the service in full. See your policy for additional information about excluded services.

Questions: Call **1-800-752-5863** or visit us at **www.sanfordhealthplan.com/memberlogin.** 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 1-800-752-5863 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $20) 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 an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care to treat an injury or illness			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	Chiropractic care			Limited to 20 visits per calendar year. Copay covers office visits and manual manipulations only. All other covered services subject to deductible and coinsurance.
	Sanford Clinic Providers	$20 copay/visit	Not covered	
	Other Participating Providers	$40 copay/visit	Not covered	
	Ancillary Services	20% coinsurance	Not covered	
	Specialist visit			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	For details, reference the Preventive Health Guidelines or contact Member Services.
If you have a test	Diagnostic test (x-ray & lab tests)			
	Includes inpatient & outpatient hospital	20% coinsurance	Not covered	——————none——————
	Medical clinic laboratory charges	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at sanfordhealthplan.com/memberlogin	Tier 1 – Generic drugs Preferred Participating Pharmacy <$75 Preferred Participant Pharmacy >=$75 Participating Pharmacy < $75 Participating Pharmacy >= $75	 $12 copay/prescription $30 copay/prescription $22 copay/prescription $40 copay/prescription	 Not covered Not covered	Generic drug tier based specifically on cost of drug. Retail drug cost less than $75 is $12 copay/prescription. Retail drug cost equal to or greater than $75 is $30 copay/prescription. Covers up to a 30-day supply. Refer to your Summary of Pharmacy Benefits/Formulary to determine which benefit tier applies to your medication. Certain oral contraceptives covered at 100%.
	Tier 2 – Formulary brand-name drugs Preferred Participating Pharmacy Participating Pharmacy	 $50 copay/prescription $60 copay/prescription	 Not covered Not covered	
	Tier 3 – Nonformulary brand-name drugs Preferred Participating Pharmacy Participating Pharmacy	 $100 copay/prescription $110 copay/prescription	 Not covered Not covered	
	Specialty drugs	20% coinsurance	Not covered	Up to a 30-day supply per prescription received from a designated specialty pharmacy. Refer to your Formulary to determine which benefit applies to your medication.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply.
	Physician/surgeon fees	20% coinsurance	Not covered	————————none————————
If you need immediate medical attention	Emergency room services	100% of in-network allowance after $300 copay/visit (1st copay waived per calendar year for employee only)	100% of in-network allowance after $300 copay/visit (1st copay waived per calendar year for employee only)	Out-of-network benefit is the same as in-network benefit unless 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 as defined by Policy. Copay waived if directly admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	————————none————————

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention (continued)	Urgent care			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply.
	Physician/surgeon fee	20% coinsurance	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	All Other Services	20% coinsurance	Not covered	
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. For full details, please refer to your policy.
	Substance use disorder outpatient services			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	All Other Services	20% coinsurance	Not covered	
	Substance use disorder inpatient services	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. For full details, please refer to your policy.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	——————none——————
	Delivery and all inpatient services	20% coinsurance	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. Limited to 40 visits per calendar year.
	Rehabilitation services	20% coinsurance	Not covered	Includes physical, speech, occupational and cardiac rehabilitation. Limited to 45 visits per therapy per calendar year.
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	20% coinsurance	Not covered	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	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. For full details, please refer to your policy.
	Hospice service	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Covered when part of a routine preventive exam.
	Glasses	Not covered	Not covered	——————none——————
	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 • Hearing aids	• Habilitation services • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private duty nursing • Routine eye care (Adult) • Weight loss programs (unless it is prescribed by a physician to accomplish treatment goals)
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	• 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 rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan toll-free at (800) 752-5863. 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) 752-5863.

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 or policy 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** $5,470
- **Patient pays** $2,070

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	$1,250
Copays	$20
Coinsurance	$600
Limits or exclusions	$200
Total	**$2,070**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,820
- **Patient pays** $1,580

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	$1,100
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,580**

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

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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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Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$2,250** person/**$4,500** family (in-network) Doesn't apply to preventive care. Out of network NOT COVERED	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?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$6,000** person/**$12,000** family (in-network) Out-of-network NOT COVERED	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, 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/memberlogin or call (800) 752-5863** 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 an in-network specialist.	You can see the in-network **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 6. Failure to obtain prior authorization may result in a denial of claims and the member will be required to pay for the service in full. See your policy for additional information about excluded services.

Questions: Call **1-800-752-5863** or visit us at **www.sanfordhealthplan.com/memberlogin.** 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 1-800-752-5863 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $20) 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 an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care to treat an injury or illness			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	Chiropractic care			Limited to 20 visits per calendar year. Copay covers office visits and manual manipulations only. All other covered services subject to deductible and coinsurance.
	Sanford Clinic Providers	$20 copay/visit	Not covered	
	Other Participating Providers	$40 copay/visit	Not covered	
	Ancillary Services	20% coinsurance	Not covered	
	Specialist visit			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	For details, reference the Preventive Health Guidelines or contact Member Services.
If you have a test	Diagnostic test (x-ray & lab tests)			
	Includes inpatient & outpatient hospital	20% coinsurance	Not covered	——————none——————
	Medical clinic laboratory charges	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at sanfordhealthplan.com/memberlogin	Tier 1 – Generic drugs Preferred Participating Pharmacy <$75 Preferred Participant Pharmacy >=$75 Participating Pharmacy < $75 Participating Pharmacy >= $75	 $12 copay/prescription $30 copay/prescription $22 copay/prescription $40 copay/prescription	 Not covered Not covered	Generic drug tier based specifically on cost of drug. Retail drug cost less than $75 is $12 copay/prescription. Retail drug cost equal to or greater than $75 is $30 copay/prescription. Covers up to a 30-day supply. Refer to your Summary of Pharmacy Benefits/Formulary to determine which benefit tier applies to your medication. Certain oral contraceptives covered at 100%.
	Tier 2 – Formulary brand-name drugs Preferred Participating Pharmacy Participating Pharmacy	 $50 copay/prescription $60 copay/prescription	 Not covered Not covered	
	Tier 3 – Nonformulary brand-name drugs Preferred Participating Pharmacy Participating Pharmacy	 $100 copay/prescription $110 copay/prescription	 Not covered Not covered	
	Specialty drugs	20% coinsurance	Not covered	Up to a 30-day supply per prescription received from a designated specialty pharmacy. Refer to your Formulary to determine which benefit applies to your medication.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply.
	Physician/surgeon fees	20% coinsurance	Not covered	————————none————————
If you need immediate medical attention	Emergency room services	100% of in-network allowance after $300 copay/visit (1st copay waived per calendar year for employee only)	100% of in-network allowance after $300 copay/visit (1st copay waived per calendar year for employee only)	Out-of-network benefit is the same as in-network benefit unless 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 as defined by Policy. Copay waived if directly admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	————————none————————

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention (continued)	Urgent care			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply.
	Physician/surgeon fee	20% coinsurance	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	All Other Services	20% coinsurance	Not covered	
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. For full details, please refer to your policy.
	Substance use disorder outpatient services			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	All Other Services	20% coinsurance	Not covered	
	Substance use disorder inpatient services	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. For full details, please refer to your policy.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	——————none——————
	Delivery and all inpatient services	20% coinsurance	Not covered	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. Limited to 40 visits per calendar year.
	Rehabilitation services	20% coinsurance	Not covered	Includes physical, speech, occupational and cardiac rehabilitation. Limited to 45 visits per therapy per calendar year.
	Habilitation services	Not covered	Not covered	——————none——————
	Skilled nursing care	20% coinsurance	Not covered	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	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. For full details, please refer to your policy.
	Hospice service	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Covered when part of a routine preventive exam.
	Glasses	Not covered	Not covered	——————none——————
	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 • Hearing aids	• Habilitation services • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private duty nursing • Routine eye care (Adult) • Weight loss programs (unless it is prescribed by a physician to accomplish treatment goals)
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	• 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 rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan toll-free at (800) 752-5863. 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:

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———————————*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** $4,670
- **Patient pays** $2,870

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	$2,250
Copays	$20
Coinsurance	$400
Limits or exclusions	$200
Total	**$2,870**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $3,820
- **Patient pays** $1,580

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	$1,100
Coinsurance	$0
Limits or exclusions	$80
Total	**$1,580**

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

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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?

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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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Sanford Health Bronze

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

Coverage Period: 01/01/2016 – 12/31/2016
Coverage for: Individual + Family
Plan Type: HMO | Non-Grandfathered

This is only a summary. If you have questions about information in this summary, or want more detail about your coverage and costs, you can get the complete terms in the policy at **http://sanfordhealthplan.com/policy/hp-0584.pdf** or by calling **(800) 752-5863** *(toll-free)* | TTY/TDD: **(877) 652-1844** *(toll-free)*.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3,250** person/**$6,500** family (in-network) Doesn't apply to preventive care. Out of network NOT COVERED	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?	No.	You don't have to meet deductibles for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes. **$6,850** person/**$13,700** family (in-network) Out-of-network NOT COVERED	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, 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/memberlogin or call (800) 752-5863** 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 an in-network specialist.	You can see the in-network **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 6. Failure to obtain prior authorization may result in a denial of claims and the member will be required to pay for the service in full. See your policy for additional information about excluded services.

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- **Copayments** are fixed dollar amounts (for example, $20) 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 an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care to treat an injury or illness			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	Chiropractic care			Limited to 20 visits per calendar year. Copay covers office visits and manual manipulations only. All other covered services subject to deductible and coinsurance.
	Sanford Clinic Providers	$20 copay/visit	Not covered	
	Other Participating Providers	$40 copay/visit	Not covered	
	Ancillary Services	20% coinsurance	Not covered	
	Specialist visit			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	Preventive care/screening/ immunization	No charge	Not covered	For details, reference the Preventive Health Guidelines or contact Member Services.
If you have a test	Diagnostic test (x-ray & lab tests)			
	Includes inpatient & outpatient hospital	20% coinsurance	Not covered	——————none——————
	Medical clinic laboratory charges	20% coinsurance	Not covered	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at sanfordhealthplan.com/memberlogin	Tier 1 – Generic drugs Preferred Participating Pharmacy <$75 Preferred Participant Pharmacy >=$75 Participating Pharmacy < $75 Participating Pharmacy >= $75	 $12 copay/prescription $30 copay/prescription $22 copay/prescription $40 copay/prescription	 Not covered Not covered	Generic drug tier based specifically on cost of drug. Retail drug cost less than $75 is $12 copay/prescription. Retail drug cost equal to or greater than $75 is $30 copay/prescription. Covers up to a 30-day supply. Refer to your Summary of Pharmacy Benefits/Formulary to determine which benefit tier applies to your medication. Certain oral contraceptives covered at 100%.
	Tier 2 – Formulary brand-name drugs Preferred Participating Pharmacy Participating Pharmacy	 $50 copay/prescription $60 copay/prescription	 Not covered Not covered	
	Tier 3 – Nonformulary brand-name drugs Preferred Participating Pharmacy Participating Pharmacy	 $100 copay/prescription $110 copay/prescription	 Not covered Not covered	
	Specialty drugs	20% coinsurance	Not covered	Up to a 30-day supply per prescription received from a designated specialty pharmacy. Refer to your Formulary to determine which benefit applies to your medication.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply.
	Physician/surgeon fees	20% coinsurance	Not covered	————————none————————
If you need immediate medical attention	Emergency room services	100% of in-network allowance after $300 copay/visit (1st copay waived per calendar year for employee only)	100% of in-network allowance after $300 copay/visit (1st copay waived per calendar year for employee only)	Out-of-network benefit is the same as in-network benefit unless 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 as defined by Policy. Copay waived if directly admitted.
	Emergency medical transportation	20% coinsurance	20% coinsurance	————————none————————

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you need immediate medical attention (continued)	Urgent care			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply.
	Physician/surgeon fee	20% coinsurance	Not covered	——————none——————
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	All Other Services	20% coinsurance	Not covered	
	Mental/Behavioral health inpatient services	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. For full details, please refer to your policy.
	Substance use disorder outpatient services			
	Sanford Clinic Providers	$20 copay/visit	Not covered	——————none——————
	Other Participating Providers	$50 copay/visit	Not covered	
	All Other Services	20% coinsurance	Not covered	
	Substance use disorder inpatient services	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. For full details, please refer to your policy.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you are pregnant	Prenatal and postnatal care	No charge	Not covered	————————none————————
	Delivery and all inpatient services	20% coinsurance	Not covered	————————none————————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. Limited to 40 visits per calendar year.
	Rehabilitation services	20% coinsurance	Not covered	Includes physical, speech, occupational and cardiac rehabilitation. Limited to 45 visits per therapy per calendar year.
	Habilitation services	Not covered	Not covered	————————none————————
	Skilled nursing care	20% coinsurance	Not covered	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	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply. For full details, please refer to your policy.
	Hospice service	20% coinsurance	Not covered	These services require certification by the Health Plan for In-network coverage levels to apply.
If your child needs dental or eye care	Eye exam	No charge	Not covered	Covered when part of a routine preventive exam.
	Glasses	Not covered	Not covered	————————none————————
	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 • Hearing aids	• Habilitation services • Infertility treatment • Long-term care • Non-emergency care when traveling outside the U.S.	• Private duty nursing • Routine eye care (Adult) • Weight loss programs (unless it is prescribed by a physician to accomplish treatment goals)
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	• 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 rights to continue coverage may also apply.

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