

Summary of Benefits and Coverage: What this Plan Covers & What You Pay For Covered Services Coverage Period: 07/01/2017-06/30/2019

North Dakota Public Employees Retirement System Grandfathered Dakota Plan

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/sanfordhealth/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 <u>network providers</u> \$500 individual / \$1,500 family. For <u>out-of-network providers</u> \$500 individual / \$1,500 family.	Generally, you must pay all of the costs from <u>providers</u> up to the <u>deductible</u> amount before this <u>plan</u> begins to pay. If you have other family members on the <u>plan</u> , each family member must meet their own individual <u>deductible</u> until the total amount of <u>deductible</u> expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. <u>Preventive care</u> and primary care services are covered before you meet your <u>deductible</u> .	This <u>plan</u> covers some items and services even if you haven't yet met the <u>deductible</u> amount. But a <u>copayment</u> or <u>coinsurance</u> may apply. For example, this <u>plan</u> covers certain <u>preventive</u> <u>services</u> without cost-sharing and before you meet your <u>deductible</u> . 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 <u>deductible</u> amount before this <u>plan</u> begins to pay for these services.
What is the <u>out-of-pocket</u> <u>limit</u> for this <u>plan</u> ?	For <u>network providers</u> \$1,500 individual / \$3,500 family. For <u>out-of-network providers</u> \$2,000 individual / \$4,500 family.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> 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 <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a provider in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a provider for the difference between the <u>provider</u> 's charge and what your <u>plan</u> pays (<u>balance-billing</u>). Be aware, your <u>network provider might</u> use an <u>out-of-network provider</u> for some services (such as lab work). Check with your provider before you get services.
Do you need a <u>referral</u> to see a specialist?	No.	You can see the in-network specialist you choose without a referral.

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All <u>copayment</u> and <u>coinsurance</u> costs shown in this chart are after your <u>deductible</u> has been met, if a <u>deductible</u> applies.

Common		What You Will Pay		Limitations, Exceptions, & Other Important	
Medical Event	Services You May Need	<u>Basic Plan After</u> <u>Deductible</u>	<u>PPO Plan After</u> <u>Deductible</u>	Information	
	Primary care visit to treat an injury or illness	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	None	
If you visit a health care provider's office or	Specialist visit	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	None	
clinic	Preventive care/screening/ immunization	\$35 <u>copay</u> /visit; <u>deductible</u> does not apply. No charge for other services.	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply. No charge for other services.	Deductible is waived. 25% <u>coinsurance</u> 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	
ii you nave a test	Imaging (CT/PET scans, MRIs)	25% coinsurance	20% coinsurance	None	
If you need drugs to	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 <u>copays</u> for a 35-100 day supply. \$1,000 <u>coinsurance</u> maximum per person per benefit period. Refer to your	
treat your illness or condition More information about prescription drug coverage is available at	Brand Name Formulary Drugs	\$25 <u>copay</u> /prescription (0-34 days) & \$50 <u>copay</u> /prescription (35-100 days) <u>deductible</u> does not apply; then 25% coinsurance.	\$25 <u>copay</u> /prescription (0-34 days) & \$50 <u>copay</u> /prescription (35-100 days) <u>deductible</u> does not apply; then 25% coinsurance.	Formulary to determine which benefit applies to your medication.	
sanfordhealthplan.com	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 <u>copays</u> for a 35-100 day supply.	
If you have outpatient	Facility fee (e.g., ambulatory surgery center)	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan.	
surgery	Physician/surgeon fees	25% coinsurance	20% coinsurance	None	

Common		What You Will Pay		Limitations, Exceptions, & Other Important
Medical Event	Services You May Need	<u>Basic Plan After</u> <u>Deductible</u>	<u>PPO Plan After</u> <u>Deductible</u>	Information
If you need immediate	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 <u>copay</u> waived if directly
medical attention	Emergency medical transportation	20% coinsurance	20% coinsurance	admitted.
	Urgent care	\$30 <u>copay</u> /visit; <u>deductible</u> does not apply	\$30 <u>copay</u> /visit; <u>deductible</u> 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.
Suy	Physician/surgeon fees	25% coinsurance	20% coinsurance	None
If you need mental health, behavioral	Outpatient services	\$35 <u>copay</u> /office visit; <u>deductible</u> does not apply and 20% <u>coinsurance</u> 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.
health, or substance abuse services	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 <u>copay</u> /office visit; <u>deductible</u> does not apply and 25% <u>coinsurance</u> 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
n you are pregnant	Childbirth/delivery professional services	25% coinsurance	20% coinsurance	care provider when a Member is enrolled in the Health Pregnancy Program.
	Childbirth/delivery facility services	25% coinsurance	20% coinsurance	

Common		What You Will Pay		Limitations, Exceptions, & Other Important
Medical Event	Services You May Need	Basic Plan After Deductible	<u>PPO Plan After</u> <u>Deductible</u>	Information
	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
If you need help recovering or have other special health needs	Habilitation services	\$30 <u>copay</u> /office visit; <u>deductible</u> does not apply and 25% <u>coinsurance</u> for other outpatient services	\$25 <u>copay</u> /office visit; <u>deductible</u> does not apply and 20% <u>coinsurance</u> for other outpatient services	None
110000	Skilled nursing care	25% coinsurance	20% coinsurance	These services require preauthorization/prior approval by the Health Plan.
	Durable medical equipment	25% <u>coinsurance</u>	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.
	Children's eye exam	Not covered	Not Covered	None
If your child needs dental or eye care	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.
Routine eye care (Adult)

Cosmetic surgeryDental care (Adult)

Long-term care

Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

Bariatric SurgeryChiropractic Care

- Coverage provided outside the United States. For full details, please refer to your Policy or see www.sanfordhealth.com/ndpers
- Private-duty nursing
- Routine foot care (for diabetics only)
- Telehealth / e-visits / video visits
- Infertility treatment; \$20,000 lifetime maximum

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 <u>Health Insurance Marketplace</u>. For more information about the <u>Marketplace</u>, visit <u>www.HealthCare.gov</u> or call 1-800-318-2596.

Your <u>Grievance</u> and <u>Appeals Rights</u>: There are agencies that can help if you have a complaint against your <u>plan</u> for a denial of a <u>claim</u>. This complaint is called a <u>grievance</u> or <u>appeal</u>. For more information about your rights, look at the explanation of benefits you will receive for that medical <u>claim</u>. Your <u>plan</u> documents also provide complete information to submit a <u>claim</u>, <u>appeal</u>, or a <u>grievance</u> for any reason to your <u>plan</u>. 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 <u>www.dol.gov/ebsa/healthreform</u>.

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 <u>plan</u> 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 <u>plan</u> 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 <u>plan</u> might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your <u>providers</u> charge, and many other factors. Focus on the <u>cost sharing</u> amounts (<u>deductibles</u>, <u>copayments</u> and <u>coinsurance</u>) and <u>excluded services</u> under the <u>plan</u>. Use this information to compare the portion of costs you might pay under different health <u>plans</u>. 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 <u>plan's</u> overall <u>deductible</u>	\$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)

In this example, Peg would pay: Cost Sharing Deductibles	
Deductibles	
Deddelibies	\$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

Total Example Cost

Durable medical equipment (glucose meter)

Total Example Goot	Ψ1,-100		
In this example, Joe would pay:			
Cost Sharing			
<u>Deductibles</u> *	\$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)

\$7.400

Durable medical equipment (crutches)

Rehabilitation services (physical therapy)

\$1,930		
In this example, Mia would pay:		
\$500		
\$200		
\$200		
\$0		
\$900		

Note: These numbers assume the patient does not participate in the <u>plan's</u> wellness program. If you participate in the <u>plan's</u> 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 <u>deductibles</u> 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:
 - o Qualified sign language interpreters
 - o 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
 - o 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 (ITY: 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: ຖ້າວ່າທ່ານເອົ້າພາສາລາວ, ການໍບິລການຊ່ວຍເຫຼື ອດ້ານພາສາ, ໂດຍ່ໍບເສັງຄ່າ, ແມ່ນ ນີ້ ຜ້ອມໃຫ້ທ່ານ. ໂທຣ 1-800-892-0675 (ITY: 1-877-652-1844).

Arabic: ال اغْوَةِ هَ الْم سِاعِدةَ خَدِهَاتَ لَهُ إِنَّ اللَّهُ الللَّهُ اللَّهُ الللْهُ اللَّهُ اللَّهُ اللَّهُ اللَّهُ اللَّهُ اللَّهُ اللَّهُ اللَّهُ الللَّهُ اللَّهُ الللْهُ اللَّهُ الللْلِهُ الللْلِلْمُ الللْلِلْمُولِلْلِلْمُ اللللْلِلْمُ الللْلِلْمُعُلِيْمُ اللْلِلْمُ اللللْلِلْمُلْلِلْمُلْلِلْمُلْلِلْمُلْلِلْمُلْلِلْمُلْلِلْمُلْلِلْلْمُلْل

Karen:

တာ်ကွဲးနိုဉ်အဝဲအာံးနှဉ်အိဉ်ဒီးတာ်ဂုံတာ်ကျိုးလာအရဒိဉ်တဖဉ်နှဉ်လီးတာ်ကွဲးနိုဉ်အဝဲအာံးအိဉ်ဒီးတာ်ဂုံတာ်ကျိုး လာအရဒိဉ်ဘဉ်ယးဒီးနှလာ်ပတံထိဉ်ဖုတဖုါ်တကျုာ်ဘာခ်ီဖျို Sanford Health Plan

နှာ်လီး ယုကျွန်ရန်းမုါသီအဓိဉ်သူဉ်လာတ်ကွဲးနိုဉ်အီးတက္ ေဘဉ်သူဉ်သုဉ်နကဘဉ်ဟံနှုံမူဒါလာမု၊ိန်းမု ဂ်သီလာတါဆာတဲာ်ယာ်လာနကတ်ယာ်နတါအိဉ်ဆူဉ်အိဉ်ချုတဉ်ကျ၊ဉ်ဘာမှတမှါတါမေးလေးနကဘဉ်ဟူဉ်အ ပူးနှာ်လီး နအိဉ်ဒီးတါခွဲးတါယာ်လာနကဒီးနှုံဘဉ်တါမေစား ဒီးတါဂ့ဂ်တါကျိုးလာနကျိုာ်နာဉ်နဲလာတလိဉ်ဟုဉ်အ ပူးဘဉ်နှဉ်လီး ကီး 1-800-892-0675 တက္ကန့

Amharic: ማስታወሻ: የሚናንሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያባዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁተር 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 (ITIY: 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:

บุปโต เปิดเรณษารับเน กากเรา เกาตรับเรากาก เสเบอร์คาญน คือเฉยรถกับบันโษคา ตะรถโต 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),

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