

| PROVIDER OF SERVICE  |  |  | PROVIDER OF SERVICE  |   |   |
|--|--|--|--|---|---|
| Covered Services   | Basic Plan<br>After Deductible Amount  | PPO Plan<br>After Deductible Amount  | Covered Services   | Basic Plan<br>After Deductible Amount   | PPO Plan<br>After Deductible Amount                         |
| <b>Grandfathered plan</b>  |  |  | <b>Non Grandfathered Plan</b>  |   |   |
| <b>Wellness Services</b>   |  |  | <b>Wellness Services</b>   |   |   |
| <p>The Plan will pay up to a Maximum Benefit Allowance of \$200 per Member per Benefit Period for any non-routine screening services not listed below or not recommended with a rating of "A" or "B" by the United States Preventive Services Task Force. Such non-routine screening services will be subject to Copayment, Deductible and Coinsurance amounts after the \$200 Benefit Allowance has been met.</p> |  |  | <p>Evidence-based items or services that have, in effect, a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, when received from a Participating Provider, are covered without payment of any deductible, copayment, or coinsurance requirement that would otherwise apply. As these recommendations change, your coverage may also change. Services performed outside of Plan Preventive Guidelines, and with a medical diagnosis, will be applied to your deductible and coinsurance.</p> |   |   |
| <ul style="list-style-type: none"> <li><b>Well Child Care to the Member's 6<sup>th</sup> birthday</b></li> </ul>   | <p>\$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.</p> <p>Benefits are available as follows:</p> <ul style="list-style-type: none"> <li>7 visits for Members from birth through 12 months;</li> <li>3 visits for Members from 13 months through 24 months; and</li> <li>1 visit per Benefit Period for Members 25 months through 72 months.</li> </ul>   | <p>\$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.</p> | <ul style="list-style-type: none"> <li><b>Well Child Care to the Member's 18<sup>th</sup> birthday</b></li> </ul>  | <p>100% of Allowed Charge. Deductible Amount is waived.</p> <p>Benefits are available as follows:</p> <ul style="list-style-type: none"> <li>Pediatric services based on guidelines supported by the HRSA, including recommendations by the American Academy of Pediatrics Bright Future pediatric schedule, and newborn metabolic screenings;</li> <li>Pediatric services based on evidence-informed preventive care and screening guidelines supported by the HRSA;</li> <li>Medical History for all children throughout development at the following ages: 0 to 11 months, 1 to 4 years, 5 to 10 years, 11 to 14 years, 15 to 17 years.</li> </ul> | <p>100% of Allowed Charge. Deductible Amount is waived.</p> |
| <ul style="list-style-type: none"> <li><b>Well Child Care Immunizations to the Member's 6<sup>th</sup> Birthday</b></li> </ul>   | <p>100% of Allowed Charge. Deductible Amount is waived.</p> <p>Covered immunizations are those that have been published as policy by the Centers for Disease Control, including DPT (Diphtheria-Pertussis-Tetanus); MMR (Measles-Mumps-Rubella); Hemophilus; Influenza B; Hepatitis; Polio; Varicella (Chicken Pox); Pneumococcal Disease; and Influenza Virus.</p>  | <p>100% of Allowed Charge. Deductible Amount is waived.</p>  | <ul style="list-style-type: none"> <li><b>Immunizations</b></li> </ul>   | <p>100% of Allowed Charge. Deductible Amount is waived.</p> <p>Immunizations are provided and covered as recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices (ACIP) and by the Health Resources and Services Administration (HRSA), with respect to the Member involved.</p>   | <p>100% of Allowed Charge. Deductible Amount is waived.</p> |
| <ul style="list-style-type: none"> <li><b>Mammography Screening Services</b></li> </ul>  | <p>100% of Allowed Charge. Deductible Amount is waived.</p> <p>Benefits are available as follows:</p> <ul style="list-style-type: none"> <li>One service for Members between the ages of 35 and 40</li> <li>One service per year for Members age 40 and older.</li> </ul> <p>Additional benefits will be available for mammography services when Medically appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 5(a).</p>   | <p>100% of Allowed Charge. Deductible Amount is waived.</p>  |  |   |   |
| <ul style="list-style-type: none"> <li><b>Preventive Screening Services for Members age 6 and older</b></li> </ul>   | <p>\$30 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.</p> <p>Benefits include:</p> <ul style="list-style-type: none"> <li>One routine physical examination per Member per Benefit Period.</li> <li>Routine diagnostic screenings.</li> <li>Routine screening procedures for cancer.</li> </ul> <p>A Health Care Provider will counsel Members as to how often preventive services are need based on the age, gender and medical status of the Member.</p> | <p>\$25 Copayment Amount per Office Visit, then 100% of Allowed Charge. Deductible Amount is waived.</p> |  |   |   |

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|   | Basic Plan<br>After Deductible Amount   | PPO Plan<br>After Deductible Amount  |
| <b>Grandfathered plan</b>                                     |   |  |
| • Routine Pap Smear   | 100% of Allowed Charge.<br>Deductible Amount is waived.<br>Benefits are subject to a Maximum Benefit Allowance of 1 Pap smear per Benefit Period.   | 100% of Allowed Charge.<br>Deductible Amount is waived.  |
| <i>Related Office Visit</i>                                   | \$30 Copayment Amount per Office Visit, then 100% of Allowed Charge.<br>Deductible Amount is waived.<br>Additional benefits will be available for Pap smears when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider. See Section 5(a).   | \$25 Copayment Amount per Office Visit, then 100% of Allowed Charge.<br>Deductible Amount is waived. |
| • Prostate Cancer Screening                                   | 75% of Allowed Charge.<br>Deductible Amount is waived.<br>Benefits are available for an annual digital rectal examination and an annual prostate-specific antigen test for the following: an asymptomatic male age 50 and older; a male age 40 and older of African American descent; and a male age 40 with a family history of prostate cancer.   | 80% of Allowed Charge.<br>Deductible Amount is waived.   |
| <i>Related Office Visit</i>                                   | \$30 Copayment Amount per Office Visit, then 100% of Allowed Charge.<br>Deductible Amount is waived.<br>Additional benefits will be available for prostate cancer screening when Medically Appropriate and Necessary and ordered by a Professional Health Care Provider.  | \$25 Copayment Amount per Office Visit, then 100% of Allowed Charge.<br>Deductible Amount is waived. |
| • Fecal Occult Blood Testing for Colorectal Cancer Screening  | 100% of Allowed Charge.<br>Deductible Amount is waived.<br>Benefits are available for Members age 50 and older, subject to a Maximum Benefit Allowance of 1 test per Benefit Period.  | 100% of Allowed Charge.<br>Deductible Amount is waived.  |
| • Dilated Eye Examination<br>(for diabetes related diagnosis) | \$30 Copayment Amount, then 75% of Allowed Charge.<br>Deductible Amount is waived.<br>Benefits are subject to a Maximum Benefit Allowance of 1 examination per Member per Benefit Period.   | \$25 Copayment Amount, then 80% of Allowed Charge.<br>Deductible Amount is waived.                   |
| Colorectal Cancer Screening                                   | Deductible Amount is waived.<br>Benefits are available for Members age 50 and older, subject to a Maximum Benefit Allowance of 1 test per Benefit Period.   | Deductible Amount is waived.   |
| • Immunizations other than Well Child Care                    | 100% of Allowed Charge.<br>Deductible Amount is waived.<br>Covered immunizations are those that have been published as policy by the Centers for Disease Control, Including Tetanus, Influenza Virus, Pneumococcal Pneumonia, MMR (Measles-Mumps-Rubella), Varicella (Chicken Pox), Shingles (Zoster) Vaccine, Meningococcal Disease and Human Papillomavirus (HPV).<br>Certain age restrictions may apply. | 100% of Allowed Charge.<br>Deductible Amount is waived.  |
| • Outpatient Nutritional Care Services                        | \$30 Copayment Amount per Office Visit, then 100% of Allowed Charge.<br>Deductible Amount is waived.<br>Benefits are available to the Maximum Benefit Allowance for the following   | \$25 Copayment Amount per Office Visit, then 100% of Allowed Charge.<br>Deductible Amount is waived. |

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|  | Basic Plan<br>After Deductible Amount  | PPO Plan<br>After Deductible Amount   |
| <b>Non Grandfathered Plan</b>                                      |  |   |
| <b>Preventive Screening Services for Members ages 18 and older</b> |  |   |
| • Routine Preventive Wellness (Physical) Examination               | 100% of Allowed Charge.<br>Deductible Amount is waived.<br>Preauthorization is not required when using a participating provider. Your annual preventive services do not need to be scheduled 12 months apart. For example, if your services were done July last year, it is okay to schedule them before July this year.   | 100% of Allowed Charge.<br>Deductible Amount is waived.<br>Office visit exam includes health advice and counseling on blood pressure, counseling and interventions on tobacco use, screening and counseling for alcohol use, sun exposure, screening for depression, obesity screening with referral for behavioral interventions for patients with a body mass index of 30 or higher and referrals to intensive behavioral counseling to promote a healthful diet and physical activity to decrease cardiovascular risk in adults that are overweight or obese and with cardiovascular disease risk factors. During the visit, you may receive immunizations/screenings based on your practitioner's recommendation. |
| • Routine Diagnostic Screenings                                    | 100% of Allowed Charge.<br>Deductible Amount is waived.<br>Screenings include, but are not limited to the following:   | 100% of Allowed Charge.<br>Deductible Amount is waived.   |
|  | <ul style="list-style-type: none"> <li>Abdominal Aortic Aneurysm Screening; Lifetime Maximum Benefit Allowance of one (1) ultrasound screening per male Member ages 65 through 75 with a history of smoking</li> <li>Anemia screening – Hemoglobin or Hematocrit (one or the other); one (1) per Member per year.</li> <li>Basic Metabolic Panel; one (1) per Member per year.</li> <li>Cholesterol Screening; coverage for frequency of Lipid Profile is dependent on Member age. Additional tests, such as comprehensive metabolic panels will be applied to your deductible/coinsurance.</li> <li>Diabetes Screening; benefit allowance of one (1) per Member per year.</li> <li>Hepatitis B Virus infection screening.</li> <li>Hepatitis C Virus (HCV) infection screening; Lifetime Maximum Benefit Allowance of either: one (1) screening for Members born between 1945-1965; or one (1) screening for Members at risk.</li> <li>Lung Cancer Screening; benefit allowance of one (1) per Member ages 55 through 80 who: 1) have a 30 pack-year smoking history; 2) currently smoke; or 3) have quit smoking within the past 15 years.</li> <li>Osteoporosis Screening for female Members ages 65 and older, or younger if at increased risk.</li> <li>Sexually Transmitted Disease (STD) Screening; one (1) per Member per year.</li> <li>Genetic counseling and evaluation for BRCA Testing and BRCA lab screening for female members with a family history (breast, ovarian, tubal, or peritoneal cancer) associated with increased risk for harmful mutation in BRC or BRC. Lifetime Maximum Benefit Allowance of one (1) screening per Member.</li> </ul> |   |
|  | For a complete listing, see the Preventive Health Guidelines for Members by signing into your account at <a href="http://www.sanfordhealthplan.com/memberlogin">www.sanfordhealthplan.com/memberlogin</a> or call  |   |

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| <b>Grandfathered plan</b> |                                       |                                     | <b>Non Grandfathered Plan</b>   |                                       |                                     |
|                           |                                       |                                     | <ul style="list-style-type: none"> <li> <b>Mammography Screening</b><br/>           100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>           • One (1) service for Members between the ages of 35 and 40.<br/>           • One (1) service per year for Members age 40 and older.<br/>           • Additional mammograms will be covered if recommended by a physician per N.D.C.C. §26.1-36-09.1.         </li> <li> <b>Cervical Cancer Screening</b><br/>           100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>           100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>           Benefits are subject to a Maximum Benefit Allowance of 1 Pap smear per Benefit Period. Includes Office Visit.         </li> <li> <b>Colorectal Cancer Screening for Members ages 50 and older</b><br/> <i>Note: Expenses incurred for tissue samples taken during a screening and sent for evaluation or colonoscopies due to a medical condition will be applied to your deductible/coinsurance.</i> <ul style="list-style-type: none"> <li> <b>Fecal Occult Blood Test; or</b><br/>               100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>               100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>               Maximum Benefit Allowance of one (1) test per Member per year.             </li> <li> <b>Colonoscopy; or</b><br/>               100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>               100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>               Maximum Benefit Allowance of one (1) test per Member every 10 years.             </li> <li> <b>Sigmoidoscopy</b><br/>               100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>               100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>               Maximum Benefit Allowance of one (1) test per Member every 5 years.             </li> </ul> </li> <li> <b>Prostate Cancer Screening</b><br/>           100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>           100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>           Benefits are available for an annual digital rectal examination and an annual prostate-specific antigen test for the following: an asymptomatic male age 50 and older; a male age 40 and older of African American descent; and a male age 40 with a family history of prostate cancer. Includes Office Visit.         </li> <li> <b>Nutritional Counseling</b><br/>           100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>           100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>           • Hyperlipidemia – Maximum of four (4) visits per Member per year.<br/>           • Gestational Diabetes – Maximum of four (4) visits per Member per year.<br/>           • Diabetes Mellitus – Maximum of four (4) visits per Member per year.<br/>           • Hypertension – Maximum of two (2) visits per Member per year.<br/>           • Obesity – Maximum of four (4) visits per Member per year.         </li> <li> <b>Aspirin to prevent cardiovascular disease</b><br/>           100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>           100% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i><br/>           Benefit is available for Male Members ages 45 through 79, and female Member ages 55 through 79 at risk for developing cardiovascular disease.         </li> </ul> |                                       |                                     |

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|                           | Basic Plan<br><i>After Deductible Amount</i> | PPO Plan<br><i>After Deductible Amount</i> |  | Basic Plan<br><i>After Deductible Amount</i> | PPO Plan<br><i>After Deductible Amount</i> |
| <b>Grandfathered plan</b> |  |  | <b>Non Grandfathered Plan</b>  |  |  |
|                           |  |  | <ul style="list-style-type: none"> <li> <b>Tobacco Cessation Services</b><br/> <i>Tobacco cessation services include screening for tobacco use and at least two (2) tobacco cessation attempts per year (for Members who use tobacco products). Covering a cessation attempt is defined to include coverage for:</i> <ul style="list-style-type: none"> <li> <i>Four (4) tobacco cessation counseling sessions of at least ten (10) minutes each (including telephone counseling, group counseling and individual counseling) without Preauthorization/Prior Approval; and</i> </li> <li> <i>All Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without Preauthorization/Prior Approval.</i> </li> </ul> </li> <li> <b>Diabetes Education Services</b><br/> 75% of Allowed Charge.                      80% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i>                      <i>Deductible Amount is waived.</i> </li> <li> <b>Dilated Eye Examination</b><br/> <i>(for diabetes related diagnosis)</i><br/> \$30 Copayment Amount, then 75% of Allowed Charge.                      \$25 Copayment Amount, then 80% of Allowed Charge.<br/> <i>Deductible Amount is waived.</i>                      <i>Deductible Amount is waived.</i><br/> <i>Maximum Benefit Allowance of 1 examination per Member per year.</i> </li> </ul> |  |  |