

OUTLINE OF BENEFITS

elite1 offers five different plan options. The following outline is a summary of benefits for In-Network coverage only. For Out-of-Network coverage, the deductible and out-of-pocket maximum amounts are double (2x) the In-Network amounts.

For a list of Providers who contract with Sanford Health Plan, please refer to Sanford Health Plan's Provider Directory at www.sanfordelite1.com or call 1-800-752-5863 to request a copy. Please remember that all benefits are subject to the definitions, limitations, and exclusions in the policy and are payable when Sanford Health Plan determines they are medically necessary.

Note: This information is a summary of coverage; please refer to the policy for actual benefits, limitations and exclusions.

| | \$1,000 Plan | \$1,500 Plan | \$2,000 Plan | \$2,500 Plan | \$3,500 | \$5,000 Plan |
|--|---|---|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| Deductible | | | | | | |
| Individual | \$1,000 | \$1,500 | \$2,000 | \$2,500 | \$3,500 | \$5,000 |
| Individual + One <i>The deductible amounts paid on behalf of either covered family member will apply towards the Individual + One deductible.</i> | \$2,000 | \$3,000 | \$4,000 | \$5,000 | \$7,000 | \$10,000 |
| Family <i>The deductible amounts paid on behalf of any combination of covered family members will apply towards the Family deductible.</i> | \$3,000 | \$4,500 | \$6,000 | \$7,500 | \$10,500 | \$15,000 |
| Maximum Out-of-Pocket | | | | | | |
| Individual | \$2,000 | \$2,500 | \$3,000 | \$3,500 | \$4,500 | \$6,000 |
| Individual + One | \$4,000 | \$5,000 | \$6,000 | \$7,000 | \$9,000 | \$12,000 |
| Family | \$6,000 | \$7,500 | \$9,000 | \$10,500 | \$13,500 | \$18,000 |
| Coinsurance: Applies after medical deductible is met. | | | | | | |
| In-Network Providers | 15% | 20% | 20% | 20% | 20% | 20% |
| Out-of-Network Providers | 25% | 40% | 40% | 40% | 40% | 40% |
| Lifetime Maximum | \$2 Million | \$2 Million | \$2 Million | \$2 Million | \$2 Million | \$2 Million |
| Office Visits. <i>Covers office visit services only, does not include lab, x-ray or other ancillary charges.</i> | \$15 copay per office visit | \$20 copay per office visit | \$20 copay per office visit | \$20 copay per office visit | \$20 copay per office visit | \$20 copay per office visit |
| X-Ray and Lab Tests. <i>During an office visit, sent out to an independent lab facility, or at an outpatient or hospital facility.</i> | 15% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Preventive Care. <i>Limited per plan guidelines.</i> | | | | | | |
| Immunizations | No Copay | No Copay | No Copay | No Copay | No Copay | No Copay |
| Routine Well Child Care (through age 6) | No Copay | No Copay | No Copay | No Copay | No Copay | No Copay |
| Routine Adult Preventive Care | \$15 Copay | \$20 Copay | \$20 Copay | \$20 Copay | \$20 Copay | \$20 Copay |
| Maternity Benefits | | | | | | |
| Inpatient Care | No Coverage | No Coverage | 20% coinsurance | No Coverage | 20% coinsurance | No Coverage |
| Routine Maternity Care <i>Includes prenatal and postnatal visits</i> | No Coverage | No Coverage | No Copay | No Coverage | No Copay | No Coverage |
| Routine Well Newborn Care (Inpatient) | No Coverage | No Coverage | 20% coinsurance | No Coverage | 20% coinsurance | No Coverage |
| Sterilization Services (tubals/vasectomies) | 15% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Transplants. <i>Limited per plan guidelines.</i> | 15% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Inpatient Hospitalization Services <i>It is the Member's responsibility to assure that any hospital stays are pre-certified through Sanford Health Plan.</i> | 15% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Outpatient Surgery <i>During an office visit, outpatient hospital settings, or at an ambulatory surgery center.</i> | 15% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Outpatient Hospital Services <i>Includes diagnostic tests, lab, X-ray, pathology, pre-surgical tests, PET, MRI, CT and nuclear medicine</i> | 15% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Emergency/Urgent Care | | | | | | |
| Emergency Care <i>As defined by Prudent Layperson in the policy.</i> | 15% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Urgent Care Office Visit | \$15 copay | \$20 copay | \$20 copay | \$20 copay | \$20 copay | \$20 copay |
| Ambulance/Emergency Transportation | 15% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Chiropractic Care. <i>Limited to 20 visits per calendar year.</i> | 15% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Chemical Dependency Services | | | | | | |
| Inpatient <i>Limited to 30 days per 6-month period 90 day lifetime maximum</i> | 15% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Outpatient <i>Limited to 30 days per 6-month period</i> | 15% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance | 20% coinsurance |
| Mental Health Care | Covered just like healthcare services for any other conditions. | | | | | |
| Prescription Drugs. <i>Copay/Coinsurance per 30-day supply. Includes oral contraceptives.</i> | | | | | | |
| Generic Drugs | 30% coinsurance after medical deductible is met | 30% coinsurance after medical deductible is met | \$20 | \$20 | \$20 | \$20 |
| Formulary Brand Name Drugs | | | \$40 | \$40 | \$40 | \$40 |
| Non-Formulary Brand Name Drugs | | | \$60 | \$60 | \$60 | \$60 |