



An Individual Sanford Health Plan Product

\$3,500 Plan

Summary of Payment

IMPORTANT INFORMATION ABOUT YOUR BENEFITS

Please remember that all benefits are subject to the definitions, limitations, and exclusions in this policy and are payable only when we determine they are Medically Necessary.

Please be aware of the following definitions as used in your Summary of Payment:

“In-Network Provider” means Covered Services that are either received:

- a. from a Participating Provider;
- b. in an Emergency Medical Condition or an urgent care situation;
- c. when the Member does not have appropriate access (as defined in Section 2) to a Participating Provider; or
- d. when a Participating Provider has recommended, and the Plan has authorized the referral to, a Non-Participating Provider.

“Out-of-Network Provider” means Covered Services that do not fit the definition of In Network Coverage set forth above. Specifically, Out-of-Network Coverage means Covered Services that are received:

- a. from Non-Participating Providers when appropriate access to a Participating Provider is available;
- b. when the Plan has not authorized the referral to a Non-Participating Provider; or
- c. for a non-emergency or non-urgent care situation.

For more information on Out-of-Network coverage, please refer to Section 4(g) in your Policy.

\$3,500 Plan		
Benefit Description	In-Network Provider	Out-of-Network Provider
1. Physician Selection	Providers who contract with Sanford Health Plan. Refer to Sanford Health Plan’s Provider Directory at www.sanfordhealthplan.com or call 1-800-752-5863 to request a copy.	Providers who do not contract with Sanford Health Plan.
2. Deductible. <i>Covered office visits copays do not apply towards the deductible.</i>		
Individual	\$3,500	\$7,000
Individual + One	\$7,000	\$14,000
<i>The deductible amounts paid on behalf of either covered family member will apply towards the Individual + One deductible.</i>		
Family	\$10,500	\$21,000
<i>The deductible amounts paid on behalf of any combination of covered family members will apply towards the Family deductible.</i>		
3. Maximum Out-of-Pocket. <i>Includes deductible and coinsurance amounts, copay amounts do not apply. The Plan will pay 100% of eligible charges after the Out-of-Pocket Maximum is met.</i>		
Individual	\$4,500	\$9,000
Individual + One	\$9,000	\$18,000
Family	\$13,500	\$27,000
4. Coinsurance. <i>Amount paid after the deductible has been met.</i>	20%	40%
5. Lifetime Maximum	\$2 Million	

6.	Office Visits. <i>Covers OV services only, does not include lab, x-ray or other ancillary charges.</i>	\$20 copay per office visit	40% coinsurance
7.	X-Ray and Lab Tests During an office visit Sent out to an independent lab facility At outpatient or hospital facility	20% coinsurance 20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance 40% coinsurance
8.	Preventive Care. <i>Limited per Plan guidelines.</i> Immunizations Routine Adult Preventive Care Routine Well Child Care <i>(through age 6)</i>	No Copay \$20 Copay No Copay	40% coinsurance 40% coinsurance 40% coinsurance
9.	Self-Injectable Medications (other than those covered under the Prescription Drug Benefit)	20% coinsurance	40% coinsurance
10.	Allergy Testing and Treatment Testing Allergy Injections (One or more) Allergy Serum (Per vial)	\$20 copay per office visit \$20 copay 20% coinsurance	40% coinsurance 40% coinsurance 40% coinsurance
11.	Sterilization Services (tubals/vasectomies)	20% coinsurance	40% coinsurance
12.	Transplants. <i>Limited per Plan Guidelines.</i>	20% coinsurance	40% coinsurance
13.	Inpatient Hospitalization Services Pre-Certification <i>It is the Member's responsibility to assure that any hospital stays are pre-certified through Sanford Health Plan</i> Non-Emergency Admissions Professional Services (includes CRNA)	20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance
14.	Outpatient Surgery During an office visit At Outpatient Hospital At Ambulatory Surgery Center	20% coinsurance 20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance 40% coinsurance
15.	Outpatient Hospital Services Includes diagnostic tests, lab, X-ray, pathology, pre-surgical tests, PET, MRI, CT and nuclear medicine	20% coinsurance	40% coinsurance
16.	Morbid Obesity Surgery. <i>Limited per Plan guidelines.</i>	20% coinsurance	40% coinsurance
17.	Emergency/Urgent Care Emergency Care As defined by <i>Prudent Layperson</i> in this policy. Urgent Care Office Visit Ambulance/Emergency Transportation	20% coinsurance. Member must notify plan within 48 hours of admission. \$20 copay per office visit 20% coinsurance	20% coinsurance. Member must notify plan within 48 hours of admission. 40% coinsurance 20% coinsurance
18.	Chiropractic Care. <i>Limited to 20 visits per calendar year.</i>	20% coinsurance	40% coinsurance
19.	Outpatient Therapy Physical, Occupational and Speech Therapy <i>Limited to 30 visits per therapy per calendar year.</i> Chemotherapy, Radiation, and IV Therapy, Dialysis Cardiac Therapy	20% coinsurance 20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance 40% coinsurance
20.	Durable Medical Equipment/Prosthetic Devices	20% coinsurance	40% coinsurance
21.	Home Health Care. <i>Limited to 40 visits per calendar year.</i>	20% coinsurance	40% coinsurance
22.	Skilled Nursing Facility. <i>Limited to 30 days per calendar year.</i>	20% coinsurance	40% coinsurance
23.	Outpatient Private Duty Nursing	20% coinsurance	40% coinsurance
24.	Hospice Care	20% coinsurance	40% coinsurance

25. Chemical Dependency Services <p style="text-align: right;">Inpatient <i>Limited to 30 days per 6-month period 90 day lifetime maximum</i></p> <p style="text-align: right;">Outpatient <i>Limited to 30 days per 6-month period</i></p>	20% coinsurance 20% coinsurance.	40% coinsurance 40% coinsurance.
26. Mental Health Care	Covered just like health care services for any other condition.	
27. Dental Care. <i>Limited to accidental coverage only. Care must be received within 6 months of injury.</i>	20% coinsurance	40% coinsurance
28. Maternity Care <p style="text-align: right;">Inpatient Care Routine Maternity Care Includes prenatal and postnatal visits Routine Well Newborn Care (Inpatient)</p>	20% coinsurance No copay 20% coinsurance	40% coinsurance
Prescription Drug Benefit Drugs must be received from a Participating Pharmacy. For a list of Participating Pharmacies, visit www.sanfordhealthplan.com or call Member Services at 1-800-752-5863 to request a copy.		
	In-Network	Out-of-Network
Generic Drugs	\$20 per 30 day supply	No Coverage
Formulary Brand Name Drugs	\$40 per 30 day supply	No Coverage
Non-Formulary Brand Name Drugs	\$60 per 30 day supply	No Coverage

DESCRIPTION OF MATERNITY BENEFITS

DEFINITIONS

For purposes of this benefit plan only, the following terms are defined as follows:

- **Eligible Family Member** means any female insured under the policy.
- **You, Your, Yours** means the Insured named on the Policy Application.

BENEFITS

The maternity benefits are subject to the same deductible and coinsurance as described in your Policy. Benefits are subject to all policy provisions and will be paid in accordance with the Benefit Provisions section of the policy. Covered Charges for maternity include the following:

Maternity Benefits

NOTE: Due to the inability to predict admission; you or your Physician must notify the Plan of your expected due date when the pregnancy is confirmed. You must also notify the Plan of the date of scheduled C-sections when it is confirmed.

Maternity care includes prenatal through postnatal maternity care and delivery and care for complication of pregnancy of mother. We cover up to two (2) routine ultrasounds per pregnancy to determine fetal age, size, and development

The Plan shall not terminate inpatient benefits or require discharge of a mother or the newborn from the Hospital following delivery earlier than determined to be medically appropriate by the attending Physician after consultation with the mother and in accordance with the guidelines established by the American Academy of Pediatrics and the American College of Obstetrics and Gynecologists, as in effect January 1, 1996.

The minimum inpatient Hospital stay, when complications are not present, ranges from a minimum of *forty-eight (48)* hours for a vaginal delivery to a minimum of *ninety-six (96)* hours for a cesarean birth, excluding the day of delivery. Such inpatient stays may be shortened if the treating Physician, after consulting with the mother, determines that the mother and child meet certain criteria and that discharge is medically appropriate. If such an inpatient stay is shortened, a post-discharge follow-up visit shall be provided to the mother and newborn by Participating Providers competent in postpartum care and newborn assessments.

NOTE: We encourage you to participate in our Healthy Pregnancy Program; Call 1-800-805-7938 to enroll.

Not covered:

- *amniocentesis or chorionic villi sampling (CVS) solely for sex determination*
- *medical and hospital costs resulting from a normal full-term delivery of a baby outside the Service Area*

Newborn Benefits

A newborn is eligible to be covered from birth. Member's must complete and sign the Plan's enrollment application form requesting coverage for the newborn within *thirty-one (31)* days of the infant's birth. For more information, see Section 1 on Enrollment and *When Dependent Coverage Begins* in your Policy.

We cover care for the enrolled newborn child from the moment of birth including care and treatment for illness, injury, premature birth and medically diagnosed congenital defects and birth abnormalities (Please refer to *Reconstructive Surgery* in Section 3(a) of your Policy for coverage information of surgery to correct congenital defects).

NOTE: You or your Physician must get Certification of neonatal intensive care nursery services. Failure to get Certification will result in a reduction or denial of benefits. (See Services requiring Certification in Section 2.)

Not covered:

- *newborn delivery and nursery charges for adopted dependents prior to the adoption bonding period*
- *medical and hospital costs resulting from a normal full-term delivery of a baby outside the Service Area*

Family Planning Benefits

Family Planning Services include consultations, and pre-pregnancy planning

Voluntary Sterilizations include tubal ligations and vasectomies

We cover voluntary sterilization performed secondary to a Cesarean section

Not covered:

- *genetic counseling or testing*
- *reproductive Health Care Services prohibited by the laws of This State*
- *elective abortion services*
- *birth control drugs and devices including but not limited to injectable contraceptive drugs implantable contraceptive devices (such as IUDs or Implanon)*
- *diaphragms, condoms or sponges*
- *sterilization of Dependent children*
- *reversal of voluntary sterilization*

Infertility Benefits

We cover testing for the diagnosis of infertility. Limited to Plan Guidelines.

Not covered:

- *treatment of infertility including artificial means of conception such as: artificial insemination, in-vitro fertilization, ovum or embryo placement or transfer, or gamete intra-fallopian tube transfer.*
- *cryogenic or other preservation techniques used in such or similar procedures;*
- *infertility medication;*
- *any other services or supplies related to artificial means of conception;*
- *reversals of prior sterilization procedures; and*
- *any expenses related to surrogate parenting*