

Sanford Health Plan offers many health and wellness benefits for members as part of their insurance premium.

- New Baby Cards
- Immunization Schedules
- Adolescent Health Program
- Birthday cards with health reminders for age appropriate health actions
 - Immunizations for those turning 12
 - Cards for men turning 40
 - Cards for women turning 18
- Preventative Health Guidelines including annual exam reminders for men and women
- Member Messenger Newsletter
- Online Health Education
- Case Management (> \$50,000 claims)
- Transplant Coordinator
- Quality Disease Management Programs



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SOUTH DAKOTA

OUTLINE OF PLANS

HEALTHCARE BUILT FOR YOU



Valley Select Plans

OUTLINE OF PLANS ¹	Valley Select \$250	Valley Select \$500
In-Network Coverage: (see Summary of Plan Benefits for out-of-network coverage)		
Calendar Year Deductible	Individual Family	\$250 \$500
Calendar Year Out of Pocket Maximum Limits	Individual Family	\$1,250 \$2,500
Coinsurance (applies after deductible has been met)		80% before out of pocket max is met 100% after out of pocket max is met
Lifetime Maximum		\$2,000,000
Medical Office Visits (covers office visit services, does not include lab, x-ray and other ancillary charges)		\$10 Copay
Preventive Health Services (see Preventive Health Guidelines)		No Copay
• Well Baby and Well Child Care (through 6 years old)		\$10 Copay
• Routine Periodic Preventive Health Exams		No Copay
• Immunizations		No Copay
Allergy Testing and Treatment		\$10 Copay
Emergency Services Copay subject to prudent layperson definition as found in the COC. Copay waived if directly admitted to facility.		\$150 Copay
Laboratory, X-ray and other Ancillary Services Includes outpatient hospital and/or medical clinic charges.		80%
Acute Inpatient Hospital Services² Includes semi-private room, general nursing care, other services and supplies as ordered by your physician. Includes hospice cottage/facility services.		80%
Maternity, Pregnancy and Newborn Care		100%
• Routine prenatal care and one postpartum visit		80%
• Hospital services		80%
Inpatient Physician Services and Consultations²		80%
Outpatient Hospital Services		80%
Outpatient Surgery²		80%
Home Health Care^{2,3}		80%
Skilled Nursing Facility Service^{2,3}		80%
Ambulance and Other Transportation Services³		80%
Mental Health Services		80%
• Inpatient ²		\$10 Copay
• Outpatient		\$10 Copay
Alcohol/Chemical/Gambling Treatment³		80%
• Inpatient ²		\$10 Copay
• Outpatient		\$10 Copay
Durable Medical Equipment and Prosthetic Devices^{2,3}		80%
Outpatient Rehabilitation Therapy Includes physical, speech, occupational therapy and cardiac rehabilitation for up to 30 visits per therapy per calendar year.		80%
Transplant Services at Designated Transplant Facilities^{2,3}		80%
Chiropractic Services Limited to 20 visits per calendar year. Office visit only.		\$10 Copay

Prescription Drug Rider

	\$10/25/40 Copay	\$15/25/40 Copay	\$15/30/50 Copay	\$15/35/50 Copay
Generic Drugs	\$10	\$15	\$15	\$15
Formulary brand-name drugs ▲	\$25	\$25	\$30	\$35
Nonformulary brand-name drugs	\$40	\$40	\$50	\$50

Prescription Drug Riders are available with or without oral contraceptives. Not available with high deductible plans.

If you choose to go to a non-participating pharmacy or fail to present your prescription ID card to your pharmacy, you must pay 100% of the cost of the medication to the pharmacy, except in an emergency.

▲ If you request a brand-name drug when there is an equivalent generic alternative available, you must pay the price difference between the brand and the generic in addition to your copay.

Office-Based Laboratory & X-ray Rider

Optional Rider: May only be added to plans with an office visit copay.

This rider replaces the following benefits listed on your Summary of Plan Benefits (SOPB).

Benefit and Examples

Preventive Health Services

Benefits are determined by age and gender. Refer to your Preventive Health Guidelines.

Medical Office Visits

Covers office visit services, labs and x-rays typically covered in a primary care setting.

Laboratory and X-ray Services With an Office Visit

Labs and x-rays typically covered in a primary care setting that occur on the same date of service as your office visit. Example: a strep throat test, x-ray for a sprain.

Laboratory and X-ray Services Without an Office Visit

If a lab or x-ray occurs without an office visit, one copay per day will apply. Example: A member has their cholesterol checked, but does not have an office visit.

Other Laboratory and X-ray Services

All inpatient and outpatient x-rays and laboratory tests, (including office visit services) billed by a hospital or surgical center, are subject to deductible and coinsurance. This also includes surgical procedures and certain other ancillary services performed in a physician's office; including but not limited to: PET scan, MRI, CT scan, SPECT scan, cardiovascular services, nuclear medicine services, radiation therapy, ultrasounds, EKG, EEG, ECG, chemotherapy and blood transfusions.

Chiropractic Services

Limited to 20 visits per calendar year. Covers office visit services, labs and x-rays.

- In Network Coverage – all services must be provided by a Sanford Health Plan participating provider.
- Out of Network Coverage – refer to Summary of Plan Benefits.
- If you have any questions, please call Member Services at (605) 328-6800 or (800) 752-5863.

In-Network

(according to your SOPB)

Your office visit copay

Your office visit copay

Covered under your office visit copay

Your office visit copay

Deductible and Coinsurance
(Coinsurance applies after deductible is met)

Your office visit copay

These plans qualify as a High Deductible Health Plan and permits individuals to establish Health Savings Accounts (HSAs) pursuant to Section 223 of the Internal Revenue Code. An individual's or a family's expense must reach the Family deductible limit before benefits will be covered.

High Deductible Plans					
High Deductible \$1,250	High Deductible \$1,500	High Deductible \$2,000	High Deductible \$2,500		
OUTLINE OF PLANS¹					
In-Network Coverage: (see Summary of Plan Benefits for out-of-network coverage)					
Calendar Year Deductible	Individual Family	\$1,250 \$2,500	\$1,500 \$3,000	\$2,000 \$4,000	\$2,500 \$5,000
Calendar Year Out of Pocket Maximum Limits	Individual Family	\$2,500 \$5,000	\$3,000 \$6,000	\$4,000 \$6,000	\$5,000 \$10,000
Coinsurance (applies after deductible has been met)		80% before out of pocket max is met 100% after out of pocket max is met	80% before out of pocket max is met 100% after out of pocket max is met	80% before out of pocket max is met 100% after out of pocket max is met	80% before out of pocket max is met 100% after out of pocket max is met
Lifetime Maximum		\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Medical Office Visits (covers office visit services, does not include lab, x-ray and other ancillary charges)		80%	80%	80%	80%
Preventive Health Services (see Preventive Health Guidelines)		100%	100%	100%	100%
• Well Baby and Well Child Care (through 6 years old)		100%	100%	100%	100%
• Routine Periodic Preventive Health Exams		100%	100%	100%	100%
• Immunizations		100%	100%	100%	100%
Allergy Testing and Treatment		80%	80%	80%	80%
Emergency Services Subject to prudent layperson definition as found in the COC.		80%	80%	80%	80%
Laboratory, X-ray and other Ancillary Services Includes outpatient hospital and/or medical clinic charges.		80%	80%	80%	80%
Acute Inpatient Hospital Services² Includes semi-private room, general nursing care, other services and supplies as ordered by your physician. Includes hospice cottage/facility services.		80%	80%	80%	80%
Maternity, Pregnancy and Newborn Care		100%	100%	100%	100%
• Routine prenatal care and one postpartum visit		80%	80%	80%	80%
• Hospital services					
Inpatient Physician Services and Consultations²		80%	80%	80%	80%
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Ambulance and Other Transportation Services³		80%	80%	80%	80%
Mental Health Services		80%	80%	80%	80%
• Inpatient ²		80%	80%	80%	80%
• Outpatient		80%	80%	80%	80%
Alcohol/Chemical/Gambling Treatment³		80%	80%	80%	80%
• Inpatient ²		80%	80%	80%	80%
• Outpatient		80%	80%	80%	80%
Durable Medical Equipment and Prosthetic Devices^{2,3}		80%	80%	80%	80%
Outpatient Rehabilitation Therapy Includes physical, speech, occupational therapy and cardiac rehabilitation for up to 30 visits per therapy per calendar year.		80%	80%	80%	80%
Transplant Services at Designated Transplant Facilities^{2,3}		80%	80%	80%	80%
Chiropractic Services Limited to 20 visits per calendar year. Office visit only.		80%	80%	80%	80%

Classic Plans - The variable copay chosen will apply throughout the plan selected.							
Classic \$500	Classic \$750	Classic \$1,000	Classic \$1,250	Classic \$1,500	Classic \$2,000	Classic \$2,500	Classic \$3,000
\$500 \$1,000	\$750 \$1,500	\$1,000 \$2,000	\$1,250 \$2,500	\$1,500 \$3,000	\$2,000 \$4,000	\$2,500 \$5,000	\$3,000 \$6,000
\$1,500 \$3,000	\$2,250 \$4,500	\$2,500 \$5,000	\$2,750 \$5,500	\$3,000 \$5,000	\$4,000 \$6,000	\$5,000 \$7,500	\$5,500 \$8,500
80% before out of pocket max is met 100% after out of pocket max is met	80% before out of pocket max is met 100% after out of pocket max is met	80% before out of pocket max is met 100% after out of pocket max is met	80% before out of pocket max is met 100% after out of pocket max is met	80% before out of pocket max is met 100% after out of pocket max is met	80% before out of pocket max is met 100% after out of pocket max is met	80% before out of pocket max is met 100% after out of pocket max is met	80% before out of pocket max is met 100% after out of pocket max is met
\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay
No Copay \$15, 20, 25 or 30 Copay No Copay	No Copay \$15, 20, 25 or 30 Copay No Copay	No Copay \$15, 20, 25 or 30 Copay No Copay	No Copay \$15, 20, 25 or 30 Copay No Copay	No Copay \$15, 20, 25 or 30 Copay No Copay	No Copay \$15, 20, 25 or 30 Copay No Copay	No Copay \$15, 20, 25 or 30 Copay No Copay	No Copay \$15, 20, 25 or 30 Copay No Copay
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\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay	\$150 Copay
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80%	80%	80%	80%	80%	80%	80%	80%
80%	80%	80%	80%	80%	80%	80%	80%
\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay	\$15, 20, 25 or 30 Copay

Prescription drug benefit included in all High Deductible plans - 80% (applies after deductible has been met)

¹ In-Network coverage levels are a percent of discounted charges that the Plan has negotiated with Participating Providers. | ² These services require prior authorization by the Health Plan for In-Network coverage levels to apply. | ³ These services may have specific coverage guidelines or limitations. See Summary of Plan Benefits or Certificate of Coverage for details. |

