

# SOUTH DAKOTA

OUTLINE OF PLANS

*Signature Series*

HEALTHCARE BUILT FOR YOU



At Sanford Health Plan, we have earned our tagline “Healthcare built for you.” With a variety of different cost sharing options, our Sanford *Signature Series* offer the flexibility to design a benefit package that meets your custom needs. You can rely on us to take the guessing out of plan design. In addition to quoting plans at your request, our team of underwriting experts recommend alternate plan designs and will explain their rating impact.



Our clients are our partners; this means we take the time to understand the financial goals of your organization in order to identify the right plan for you.

## Signature Series

OUTLINE OF PLANS		In Network <sup>1</sup>
<b>Calendar Year Deductible</b>	Individual Family	\$[100-\$5,000] \$[2x the individual deductible]
<b>Coinsurance</b> (applies after deductible has been met)	Individual Family	[70-90]% (in 5% increments) 100%
<b>Calendar Year Out of Pocket Maximum Limits</b>	Individual Family	\$[2x or 3x the individual deductible] \$[2x the individual out of pocket max]
<b>Lifetime Maximum</b>		\$2,000,000
<b>Medical Office Visits</b> Copay covers office visit services. Does not include lab, x-ray and other ancillary charges	Flat Copay  Two Tier Copay  <i>The spread between the Primary and Specialty copays is set at \$25</i>	\$[10-50] (\$5 increments up to \$35)  \$[10-50] Primary Care Copay \$[35-75] Specialty Care Copay
<b>Preventive Health Services</b> (see Preventive Health Guidelines) Well Baby and Well Child Care (through 6 years old) Routine Periodic Preventive Health Exams Immunizations		No Copay \$[10-50] Copay No Copay
<b>Allergy Testing and Treatment</b>		\$[10-50] Copay
<b>Emergency Services</b> Copay subject to prudent layperson definition as found in the Certificate of Coverage. Copay waived if directly admitted to facility.		\$[50-150] Copay
<b>Laboratory, X-ray and other Ancillary Services</b> Includes outpatient hospital and/or medical clinic charges.		[70-90]%
<b>Acute Inpatient Hospital Services<sup>2</sup></b> Includes semi-private room, general nursing care, other services and supplies as ordered by your physician. Includes hospice cottage/facility services.		[70-90]%
<b>Maternity, Pregnancy and Newborn Care</b> Routine prenatal care and one postpartum visit Hospital services		100% [70-90]%
<b>Inpatient Physician Services and Consultations<sup>2</sup></b>		[70-90]%
<b>Outpatient Hospital Services</b>		[70-90]%
<b>Outpatient Surgery<sup>2</sup></b>		[70-90]%
<b>Home Health Care<sup>2,3</sup></b>		[70-90]%
<b>Skilled Nursing Facility Service<sup>2,3</sup></b>		[70-90]%
<b>Ambulance and Other Transportation Services<sup>3</sup></b>		[70-90]%
<b>Mental Health Services<sup>3</sup></b> Inpatient <sup>2</sup> /Partial Hospitalization Outpatient		[70-90]% \$[10-50] Copay
<b>Alcohol/Chemical/Gambling Treatment<sup>3</sup></b> Inpatient <sup>2</sup> /Intensive Outpatient Programs Outpatient		[70-90]% \$[10-50] Copay
<b>Durable Medical Equipment and Prosthetic Devices<sup>2,3</sup></b>		[70-90]%
<b>Outpatient Rehabilitation Therapy</b> Includes physical, speech, occupational therapy and cardiac rehabilitation for up to 30 visits per therapy per calendar year.		[70-90]%
<b>Transplant Services at Designated Transplant Facilities<sup>2,3</sup></b>		[70-90]%
<b>Chiropractic Services</b> Limited to 20 visits per calendar year. Covers office visits and manual manipulations only. All other covered services subject to deductible and coinsurance.		\$[10-50] Copay

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

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

OUTLINE OF PLANS	High Deductible \$1,250	High Deductible \$1,500	High Deductible \$2,000	High Deductible \$2,500	
<b>In-Network Coverage<sup>1</sup>:</b>					
<b>Calendar Year Deductible</b>	Individual Family	\$1,250 \$2,500	\$1,500 \$3,000	\$2,000 \$4,000	\$2,500 \$5,000
<b>Coinsurance (applies after deductible has been met)</b>		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
<b>Calendar Year Out of Pocket Maximum Limits</b>	Individual Family	\$2,500 \$5,000	\$3,000 \$6,000	\$4,000 \$6,000	\$5,000 \$10,000
<b>Lifetime Maximum</b>		\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
<b>Medical Office Visits (covers office visit services, does not include lab, x-ray and other ancillary charges)</b>		80%	80%	80%	80%
<b>Preventive Health Services (see Preventive Health Guidelines)</b>					
<ul style="list-style-type: none"> <li>• Well Baby and Well Child Care (through 6 years old)</li> <li>• Routine Periodic Preventive Health Exams</li> <li>• Immunizations</li> </ul>		100% 100% 100%	100% 100% 100%	100% 100% 100%	100% 100% 100%
<b>Allergy Testing and Treatment</b>		80%	80%	80%	80%
<b>Emergency Services</b> Subject to prudent layperson definition as found in the Certificate of Coverage.		80%	80%	80%	80%
<b>Laboratory, X-ray and other Ancillary Services</b> Includes outpatient hospital and/or medical clinic charges.		80%	80%	80%	80%
<b>Acute Inpatient Hospital Services<sup>2</sup></b> 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%
<b>Maternity, Pregnancy and Newborn Care</b>					
<ul style="list-style-type: none"> <li>• Routine prenatal care and one postpartum visit</li> <li>• Hospital services</li> </ul>		100% 80%	100% 80%	100% 80%	100% 80%
<b>Inpatient Physician Services and Consultations<sup>2</sup></b>		80%	80%	80%	80%
<b>Outpatient Hospital Services</b>		80%	80%	80%	80%
<b>Outpatient Surgery<sup>2</sup></b>		80%	80%	80%	80%
<b>Home Health Care<sup>2,3</sup></b>		80%	80%	80%	80%
<b>Skilled Nursing Facility Service<sup>2,3</sup></b>		80%	80%	80%	80%
<b>Ambulance and Other Transportation Services<sup>3</sup></b>		80%	80%	80%	80%
<b>Mental Health Services<sup>3</sup></b>					
<div style="text-align: right; padding-right: 20px;">                     Inpatient<sup>2</sup>/Partial Hospitalization Outpatient                 </div>		80% 80%	80% 80%	80% 80%	80% 80%
<b>Alcohol/Chemical/Gambling Treatment<sup>3</sup></b>					
<div style="text-align: right; padding-right: 20px;">                     Inpatient<sup>2</sup>/Intensive Outpatient Programs Outpatient                 </div>		80% 80%	80% 80%	80% 80%	80% 80%
<b>Durable Medical Equipment and Prosthetic Devices<sup>2,3</sup></b>		80%	80%	80%	80%
<b>Outpatient Rehabilitation Therapy</b> Includes physical, speech, occupational therapy and cardiac rehabilitation for up to 30 visits per therapy per calendar year.		80%	80%	80%	80%
<b>Transplant Services at Designated Transplant Facilities<sup>2,3</sup></b>		80%	80%	80%	80%
<b>Chiropractic Services</b> Limited to 20 visits per calendar year. Covers office visits and manual manipulations only. All other covered services subject to deductible and coinsurance.		80%	80%	80%	80%
<b>Prescription Drug</b>		80%	80%	80%	80%

# Prescription Drug Rider Options

	\$10/25/40 Copay	\$10/25/50 Copay	\$15/25/40 Copay	\$10/30/50 Copay	\$15/30/50 Copay	\$10/35/50 Copay	\$15/35/50 Copay	\$15/50/75 Copay
Generic Drugs	\$10	\$10	\$15	\$10	\$15	\$10	\$15	\$15
Formulary brand-name drugs	\$25	\$25	\$25	\$30	\$30	\$35	\$35	\$50
Nonformulary brand-name drugs	\$40	\$50	\$40	\$50	\$50	\$50	\$50	\$75

**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

Your office visit copay

Your office visit copay

Deductible and Coinsurance  
(Coinsurance applies after deductible is met)

Your office visit copay

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

- Welcome 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
- Preventive Health Guidelines including annual exam reminders for men and women
- Member Messenger Newsletter
- Online Health Education
- Complex Nurse Case Management
- Transplant Coordinator
- Quality Disease Management Programs





# Sanford Health Plan

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