$1,500 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) of your Policy.

$1,500 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.** *Covered office visits copays do not apply towards the deductible.*		
	Individual	$1,500	$3,000
	Individual + One *The deductible amounts paid on behalf of either covered family member will apply towards the Individual + One deductible.*	$3,000	$6,000
	Family *The deductible amounts paid on behalf of any combination of covered family members will apply towards the Family deductible.*	$4,500	$9,000
3.	**Maximum Out-of-Pocket.** *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.*		
	Individual	$2,500	$5,000
	Individual + One	$5,000	$10,000
	Family	$7,500	$15,000
4.	**Coinsurance.** *Amount paid after the deductible has been met.*	20%	40%
5.	**Lifetime Maximum**	$2 Million	

#	Service		
6.	**Office Visits.** *Covers OV services only, does not include lab, x-ray or other ancillary charges.*	$20 copay per office visit	40% coinsurance
7.	**X-Ray and Lab Tests**		
	During an office visit	20% coinsurance	40% coinsurance
	Sent out to an independent lab facility	20% coinsurance	40% coinsurance
	At outpatient or hospital facility	20% coinsurance	40% coinsurance
8.	**Preventive Care.** *Limited per Plan guidelines.*		
	Immunizations	No Copay	40% coinsurance
	Routine Adult Preventive Care	$20 Copay	40% coinsurance
	Routine Well Child Care *(through age 6)*	No Copay	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	$20 copay per office visit	40% coinsurance
	Allergy Injections (One or more)	$20 copay	40% coinsurance
	Allergy Serum (Per vial)	20% coinsurance	40% coinsurance
11.	**Sterilization Services** (tubals/vasectomies)	20% coinsurance	40% coinsurance
12.	**Transplants.** *Limited per Plan Guidelines.*	20% coinsurance	40% coinsurance
13.	**Inpatient Hospitalization Services**		
	Pre-Certification *It is the Member's responsibility to assure that any hospital stays are pre-certified through Sanford Health Plan*		
	Non-Emergency Admissions	20% coinsurance	40% coinsurance
	Professional Services	20% coinsurance	40% coinsurance
14.	**Outpatient Surgery**		
	During an office visit	20% coinsurance	40% coinsurance
	At outpatient hospital	20% coinsurance	40% coinsurance
	At ambulatory surgery center	20% 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.** *Limited per Plan guidelines.*	20% coinsurance	40% coinsurance
17.	**Emergency/Urgent Care**		
	Emergency Care As defined by *Prudent Layperson* in this policy.	20% coinsurance. Member must notify plan within 48 hours of admission.	20% coinsurance. Member must notify plan within 48 hours of admission.
	Urgent Care Office Visit	$20 copay per office visit	40% coinsurance
	Ambulance/Emergency Transportation	20% coinsurance	20% coinsurance
18.	**Chiropractic Care.** *Limited to 20 visits per calendar year.*	20% coinsurance	40% coinsurance
19.	**Outpatient Therapy**		
	Physical, Occupational and Speech Therapy *Limited to 30 visits per therapy per calendar year.*	20% coinsurance	40% coinsurance
	Chemotherapy, Radiation, and IV Therapy, Dialysis	20% coinsurance	40% coinsurance
	Cardiac Therapy	20% coinsurance	40% coinsurance
20.	**Durable Medical Equipment/Prosthetic Devices**	20% coinsurance	40% coinsurance
21.	**Home Health Care.** *Limited to 40 visits per calendar year.*	20% coinsurance	40% coinsurance
22.	**Skilled Nursing Facility.** *Limited to 30 days per calendar year.*	20% coinsurance	40% coinsurance
23.	**Outpatient Private Duty Nursing**	20% coinsurance	40% coinsurance
24.	**Hospice Care**	20% coinsurance	40% coinsurance

25. Chemical Dependency Services **Inpatient** *Limited to 30 days per 6-month period* *90 day lifetime maximum* **Outpatient** *Limited to 30 days per 6-month period*	20% coinsurance 20% coinsurance	40% coinsurance 40% coinsurance
26. Mental Health Care **Inpatient** **Outpatient**	20% coinsurance $20 copay	40% coinsurance 40% coinsurance
26. Mental Health Care		
27. Dental Care. *Limited to accidental coverage only. Care must be received within 6 months of injury.*	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	30% coinsurance per 30 day supply	No Coverage
Formulary Brand Name Drugs	30% coinsurance per 30 day supply	No Coverage
Non-Formulary Brand Name Drugs	30% coinsurance per 30 day supply	No Coverage