



An Individual Sanford Health Plan Product

\$5,000 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.

\$5,000 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 Individual + One <i>The deductible amounts paid on behalf of either covered family member will apply towards the Individual + One deductible.</i> Family <i>The deductible amounts paid on behalf of any combination of covered family members will apply towards the Family deductible.</i>	\$5,000 \$10,000 \$15,000	\$10,000 \$20,000 \$30,000
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 Individual + One Family	\$6,000 \$12,000 \$18,000	\$12,000 \$24,000 \$36,000
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 (through age 6)	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	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 <i>As defined by Prudent Layperson in this policy.</i> 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 Inpatient <i>Limited to 30 days per 6-month period</i> <i>90 day lifetime maximum</i> Outpatient <i>Limited to 30 days per 6-month period</i>	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. <i>Limited to accidental coverage only. Care must be received within 6 months of injury.</i>	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