

Sanford Health Plan – New Plan Design



State: SD

Benefits 2010

		In-Network Coverage	
Plan facts	Member services	(800) 752-5863	Annual enrollment information: (800) 752-5863
	Member services hours	Mon-Fri: 7:30 AM-5:00 PM CT	
	Web address	www.sanfordhealthplan.com	
	Product name	Sanford Health Plan	
Your medical expenses	Annual deductible	\$500 (individual) / \$1,000 (family max)*	
	Out-of-pocket maximum (includes deductible)	\$3,000 (individual) / \$6,000 (family max) per calendar year*	
	Office visits	Covered at 90% after deductible	
	Maternity care prenatal office visits	Covered at 90% after deductible	
	Inpatient hospitalization	Covered at 90% after deductible	
	Outpatient surgical care	Covered at 90% after deductible	
	Outpatient lab and X-ray	Covered at 90% after deductible	
	Emergency room care	\$100 copay/visit (waived if admitted)*	
Your prescription drug expenses	Retail	\$10 copay (generic), \$20 copay (preferred brand), \$40 copay (non-preferred brand) per prescription up to 30-day supply	
	Mail order	\$30 copay (generic), \$60 copay (preferred brand), \$120 copay (non-preferred brand) per prescription up to 90-day supply	
Preventive care	Routine physical and GYN exam	Covered at 100%, no deductible	
	Routine vision exam	Covered at 100%, no deductible. Limit 1 exam per 24 months	
	Well-child care and immunizations	Covered at 100%, no deductible	
	Routine mammography	Covered at 100%, no deductible	
Mental health	Inpatient	Covered at 90% after deductible	
	Outpatient	Covered at 90% after deductible	
Substance abuse	Inpatient detoxification	Covered at 90% after deductible*	
	Inpatient rehabilitation	Covered at 90% after deductible*	
	Outpatient detoxification	Covered at 90% after deductible*	
	Outpatient rehabilitation	Covered at 90% after deductible*	
Other professional care	Outpatient physical/speech/occupational therapy	Covered at 90% after deductible. Limit 60 visits per year for physical, speech and occupational therapy combined	
	Chiropractic care	Covered at 90% after deductible. Limit 20 visits per year	
	Infertility	Diagnosis: Covered at 90% after deductible. Treatment/Artificial Insemination/In vitro: Not covered. Contact plan for details	
Out-of-network coverage	Out-of-network non-emergency care	Not covered	
Key facts	NCQA status:	Excellent	Domestic partner coverage available: Yes
	PCP referral required for specialist:	No	Domestic partner children coverage avail.: Yes
	Lifetime maximum benefit:	NA	
	Provider network:	See website for details	

* Indicates a benefit change

The information contained in this summary is for comparative purposes and does not include all benefits, limitations, and exclusions.