Sanford Health Plan

State: SD **Benefits 2011**

		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)
	Urgent care facility	Covered at 90% after deductible
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 name), $120 copay (non-preferred brand name) per prescription up to 90-day supply
Preventive care	Routine physical and GYN exam	Covered at 100%, no deductible. Limits apply
	Routine vision exam	Covered at 100%, no deductible. Limit 1 exam per 24 months
	Well-child care and immunizations	Covered at 100%, no deductible. Llimits apply. Contact Plan for details*
	Routine mammography	Covered at 100%, no deductible. Limits apply
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 (Pending)	Domestic partner coverage available:	Yes
	PCP referral required for specialist:	No	Domestic partner children coverage available:	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.