

Sanford Health Plan

<http://www.sanfordhealthplan.com>

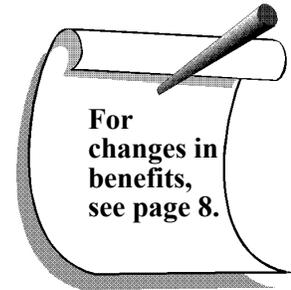


2009

A Health Maintenance Organization and a point of service product

Serving: Central, Eastern South Dakota and the Rapid City area, and Northwestern Iowa

Enrollment in this plan is limited. You must live or work in our Geographic service area to enroll. See page 6 for requirements.



Sanford Health Plan's Commercial HMO product received NCQA's Excellent Accreditation Status.

Enrollment codes for this Plan:

- AU1 High Option - Self Only**
- AU2 High Option - Self and Family**
- AU4 Standard Option - Self Only**
- AU5 Standard Option - Self and Family**



Authorized for distribution by the:



**United States
Office of Personnel Management**
Center for
Retirement and Insurance Services
<http://www.opm.gov/insure>

RI 73-814

Important Notice from Sanford Health Plan About Our Prescription Drug Coverage and Medicare

OPM has determined that Sanford Health Plan's prescription drug coverage is, on average, comparable to Medicare Part D prescription drug coverage; thus you do not need to enroll in Medicare Part D and pay extra for prescription drug benefits. If you decide to enroll in Medicare Part D later, you will not have to pay a penalty for late enrollment as long as you keep your FEHB coverage.

However, if you choose to enroll in Medicare Part D, you can keep your FEHB coverage and will coordinate benefits with Medicare.

Remember: If you are an annuitant and you cancel your FEHB coverage, you may not re-enroll in the FEHB Program.

Please be advised

If you lose or drop your FEHB coverage, you will have to pay a higher Part D premium if you go without equivalent prescription drug coverage for a period of 63 days or longer. If you enroll in Medicare Part D at a later date, your premium will increase 1 percent per month for each month you did not have equivalent prescription drug coverage. For example, if you go 19 months without Medicare Part D prescription drug coverage, your premium will always be at least 19 percent higher than what most other people pay. You may also have to wait until the next open enrollment period to enroll in Medicare Part D.

Medicare's Low Income Benefits

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA) online at www.socialsecurity.gov, or call the SSA at 1-800-772-1213 (TTY 1-800-325-0778).

You can get more information about Medicare prescription drug plans and the coverage offered in your area from these places:

- Visit www.medicare.gov for personalized help,
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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Introduction

This brochure describes the benefits of under our contract (CS 2843) with the United States Office of Personnel Management, as authorized by the Federal Employees Health Benefits law. The address for administrative offices is:

Sanford Health Plan
PO Box 91110
Sioux Falls, SD 57109-1110

This brochure is the official statement of benefits. No oral statement can modify or otherwise affect the benefits, limitations, and exclusions of this brochure. It is your responsibility to be informed about your health benefits.

If you are enrolled in this Plan, you are entitled to the benefits described in this brochure. If you are enrolled in Self and Family coverage, each eligible family member is also entitled to these benefits. You do not have a right to benefits that were available before January 1, 2009, unless those benefits are also shown in this brochure.

OPM negotiates benefits and rates with each plan annually. Benefit changes are effective January 1, 2009, and changes are summarized on page 8. Rates are shown at the end of this brochure.

Plain Language

All FEHB brochures are written in plain language to make them responsive, accessible, and understandable to the public. For instance,

- Except for necessary technical terms, we use common words. For instance, “you” means the enrollee or family member, “we” means Sanford Health Plan.
- We limit acronyms to ones you know. FEHB is the Federal Employees Health Benefits Program. OPM is the United States Office of Personnel Management. If we use others, we tell you what they mean first.
- Our brochure and other FEHB plans’ brochures have the same format and similar descriptions to help you compare plans.

If you have comments or suggestions about how to improve the structure of this brochure, let OPM know. Visit OPM’s “Rate Us” feedback area at www.opm.gov/insure or e-mail OPM at fehwebcomments@opm.gov. You may also write to OPM at the U.S. Office of Personnel Management, Insurance Services Programs, Program Planning & Evaluation Group, 1900 E Street, NW, Washington, DC 20415-3650.

Stop Health Care Fraud!

Fraud increases the cost of health care for everyone and increases your Federal Employees Health Benefits Program premium.

OPM’s Office of the Inspector General investigates all allegations of fraud, waste, and abuse in the FEHB Program regardless of the agency that employs you or from which you retired.

Protect Yourself From Fraud – Here are some things that you can do to prevent fraud:

- Be wary of giving your plan identification (ID) number over the telephone or to people you do not know, except to your doctor, other provider, or authorized plan or OPM representative.
- Let only the appropriate medical professionals review your medical record or recommend services.
- Avoid using health care providers who say that an item or service is not usually covered, but they know how to bill us to get it paid.
- Carefully review explanations of benefits (EOBs) statements that you receive from us.
- Do not ask your doctor to make false entries on certificates, bills or records in order to get us to pay for an item or service.

- If you suspect that a provider has charged you for services you did not receive, billed you twice for the same service, or misrepresented any information, do the following:
 - Call the provider and ask for an explanation. There may be an error.
 - If the provider does not resolve the matter, call us at (605) 328-6868 and explain the situation.
 - If we do not resolve the issue:

CALL - THE HEALTH CARE FRAUD HOTLINE

202-418-3300

OR WRITE TO:

United States Office of Personnel Management

Office of the Inspector General Fraud Hotline

1900 E Street NW Room 6400

Washington, DC20415-1100

- Do not maintain as a family member on your policy:
 - Your former spouse after a divorce decree or annulment is final (even if a court order stipulates otherwise); or
 - Your child over age 22 (unless he/she is disabled and incapable of self support).
- If you have any questions about the eligibility of a dependent, check with your personnel office if you are employed, with your retirement office (such as OPM) if you are retired, or with the National Finance Center if you are enrolled under Temporary Continuation of Coverage.
- You can be prosecuted for fraud and your agency may take action against you if you falsify a claim to obtain FEHB benefits or try to obtain services for someone who is not an eligible family member or who is no longer enrolled in the Plan.

Preventing medical mistakes

An influential report from the Institute of Medicine estimates that up to 98,000 Americans die every year from medical mistakes in hospitals alone. That's about 3,230 preventable deaths in the FEHB Program a year. While death is the most tragic outcome, medical mistakes cause other problems such as permanent disabilities, extended hospital stays, longer recoveries, and even additional treatments. By asking questions, learning more and understanding your risks, you can improve the safety of your own health care, and that of your family members. Take these simple steps:

1. Ask questions if you have doubts or concerns.

- Ask questions and make sure you understand the answers.
- Choose a doctor with whom you feel comfortable talking.
- Take a relative or friend with you to help you ask questions and understand answers.

2. Keep and bring a list of all the medicines you take.

- Bring the actual medicines or give your doctor and pharmacist a list of all the medicines that you take, including non-prescription (over-the-counter) medicines.
- Tell them about any drug allergies you have.
- Ask about any risks or side effects of the medication and what to avoid while taking it. Be sure to write down what your doctor or pharmacist says.

- Make sure your medicine is what the doctor ordered. Ask the pharmacist about your medicine if it looks different than you expected.
- Read the label and patient package insert when you get your medicine, including all warnings and instructions.
- Know how to use your medicine. Especially note the times and conditions when your medicine should and should not be taken.

3. Get the results of any test or procedure.

- Ask when and how you will get the results of tests or procedures.
- Don't assume the results are fine if you do not get them when expected, be it in person, by phone, or by mail.
- Call your doctor and ask for your results.
- Ask what the results mean for your care.

4. Talk to your doctor about which hospital is best for your health needs.

- Ask your doctor about which hospital has the best care and results for your condition if you have more than one hospital to choose from to get the health care you need.
- Be sure you understand the instructions you get about follow-up care when you leave the hospital.

5. Make sure you understand what will happen if you need surgery.

- Make sure you, your doctor, and your surgeon all agree on exactly what will be done during the operation.
- Ask your doctor, "Who will manage my care when I am in the hospital?"
- Ask your surgeon:
 - Exactly what will you be doing?
 - About how long will it take?
 - What will happen after surgery
 - How can I expect to feel during recovery?
- Tell the surgeon, anesthesiologist, and nurses about any allergies, bad reaction to anesthesia, and any medications you are taking.

Want more information on patient safety?

- www.ahrq.gov/path/beactive. The Agency for Healthcare Research and Quality makes available a wide-ranging list of topics not only to inform consumers about patient safety but to help choose quality health care providers and improve the quality of care you receive.
- www.npsf.org. The National Patient Safety Foundation has information on how to ensure safer health care for you and your family.
- www.talkaboutrx.org. The National Council on Patient Information and Education is dedicated to improving communication about the safe, appropriate use of medicines.
- www.leapfroggroup.org. The Leapfrog Group is active in promoting safe practices in hospital care.
- www.ahqa.org. The American Health Quality Association represents organizations and health care professionals working to improve patient safety.
- www.quic.gov/report. Find out what federal agencies are doing to identify threats to patient safety and help prevent mistakes in the nation's health care delivery system.

Section 1. Facts about this HMO Plan

This Plan is a health maintenance organization (HMO). We require you to see specific physicians, hospitals, and other providers that contract with us. These Plan providers coordinate your health care services. The Plan is solely responsible for the selection of these providers in your area. Contact the Plan for a copy of their most recent provider directory.

HMOs emphasize preventive care such as routine office visits, physical exams, well-baby care, and immunizations, in addition to treatment for illness and injury. Our providers follow generally accepted medical practice when prescribing any course of treatment.

When you receive services from Plan providers, you will not have to submit claim forms or pay bills. You pay only the copayments, coinsurance, and deductibles described in this brochure. When you receive emergency services from non-Plan providers, you may have to submit claim forms.

You should join an HMO because you prefer the plan's benefits, not because a particular provider is available. You cannot change plans because a provider leaves our Plan. We cannot guarantee that any one physician, hospital, or other provider will be available and/or remain under contract with us.

We have Open Access benefits

Our HMO offers Open Access benefits. This means you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

We have Point of Service (POS) benefits

Our HMO offers Point of Service (POS) benefits. This means you can receive covered services from a non-participating provider. However, out-of-network benefits may have higher out-of-pocket costs than our in-network benefits.

General features of our High and Standard Plan Options

Our HMO offers POS benefits. This means you can receive covered services from a participating provider without a required referral, or from a non-participating provider. These out-of-network benefits have higher out-of-pocket costs than our in-network benefits.

How we pay providers

We contract with individual physicians, medical groups, and hospitals to provide the benefits in this brochure. These Plan providers accept a negotiated payment from us, and you will only be responsible for your copayments or coinsurance.

Your Rights

We will keep your medical and claims records confidential. Please note that we may disclose your medical and claims information (including your prescription drug utilization) to any of your treating physicians or dispensing pharmacies.

OPM requires that all FEHB plans provide certain information to their FEHB members. You may get information about us, our networks, providers, and facilities. OPM's FEHB Web site (www.opm.gov/insure) lists the specific types of information that we must make available to you. Some of the required information is listed below.

- **Years in existence**
- **Profit status**

If you want more information about us, call 800-752-5863, or write to Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. You may also contact us by fax at 605-328-6812 or visit our website at www.sanfordhealthplan.com.

Service Area

To enroll in this Plan, you must live in or work in our Service Area. This is where our providers practice. Our service area is:

In South Dakota our service area is: Aurora, Beadle, Bennett, Bon Homme, Brookings, Brown, Brule, Buffalo, Butte, Campbell, Charles Mix, Clark, Clay, Codington, Davison, Day , Deuel, Douglas, Edmunds, Faulk, Grant, Gregory, Hamlin, Hand, Hanson, Hughes, Hutchinson, Hyde, Jerauld, Kingsbury, Lake, Lawrence, Lincoln, Lyman, Marshall, McCook, McPherson, Meade, Miner, Minnehaha, Moody, Pennington, Potter, Roberts, Sanborn, Spink, Stanley, Sully, Todd, Tripp, Turner, Union, Walworht, and Yankton.

In Iowa our service area is: Clay, Dickinson, Emmet, Ida, Lyon, O'Brien, Ocseola, Plymouth, and Sioux.

Ordinarily, you must get your care from providers who contract with us. If you receive care outside our service area, we will pay only for emergency care benefits. We will not pay for any other health care services out of our service area unless the services have prior plan approval.

If you or a covered family member move outside of our service area, you can enroll in another plan. If your dependents live out of the area (for example, if your child goes to college in another state), you should consider enrolling in a fee-for-service plan or an HMO that has agreements with affiliates in other areas. If you or a family member move, you do not have to wait until Open Season to change plans. Contact your employing or retirement office.

Section 2. How we changed for 2009

Do not rely only on these change descriptions; this Section is not an official statement of benefits. For that, go to Section 5 Benefits. Also, we edited and clarified language throughout the brochure; any language change not shown here is a clarification that does not change benefits.

Changes to the High Option Only

Your share of the non-postal premium will increase for Self only or for Self and Family. See page 70.

Changes to the Standard Option Only

Your share of the non-postal premium will increase for Self only or for Self and Family. See page 70.

Section 3. How you get care

Identification cards

We will send you an identification (ID) card when you enroll. You should carry your ID card with you at all times. You must show it whenever you receive services from a Plan provider, or fill a prescription at a Plan pharmacy. Until you receive your ID card, use your copy of the Health Benefits Election Form, SF-2809, your health benefits enrollment confirmation (for annuitants), or your electronic enrollment system (such as Employee Express) confirmation letter.

If you do not receive your ID card within 30 days after the effective date of your enrollment, or if you need replacement cards, call us at 1-800-752-5863 or write to us at PO Box 91110 Sioux Falls, SD 57109-1110. You may also request replacement cards through our website at www.sanfordhealthplan.com.

Where you get covered care

You get care from “Plan providers” and “Plan facilities.” You will only pay copayments, deductibles, and/or coinsurance. If you use our point-of-service program, you can also get care from non-Plan providers but it will cost you more. If you use our Open Access program you can receive covered services from a participating provider without a required referral from your primary care physician or by another participating provider in the network.

- **Plan providers**

Plan providers are physicians and other health care professionals in our service area that we contract with to provide covered services to our members. We credential Plan providers according to national standards.

We list Plan providers in the provider directory, which we update periodically. The list is also on our Web site.

- **Plan facilities**

Plan facilities are hospitals and other facilities in our service area that we contract with to provide covered services to our members. We list these in the provider directory, which we update periodically. The list is also on our Web site.

What you must do to get covered care

It depends on the type of care you need. First, you and each family member should choose a primary care physician. This decision is important since your primary care physician provides or arranges for most of your health care.

- **Primary care**

Your primary care physician can be a family practitioner, internist, pediatrician, general practitioner or OB/GYN. Your primary care physician will provide most of your health care, or give you a referral to see a specialist. Appropriate access for Primary Care Physicians and Hospital Provider sites is within thirty (30) miles of your city of residence. Appropriate access includes access to our providers when you have traveled outside of the service area. If you are traveling within the service area where other Plan providers are available then you must use Plan providers

If you want to change primary care physicians or if your primary care physician leaves the Plan, call us. We will help you select a new one.

- **Specialty care**

Your primary care physician may refer you to a specialist for needed care. However, you may also self-refer to Plan specialist providers. No referral is necessary. Appropriate access for Specialty Physicians and Hospital Provider sites is within ninety (90) miles of your city of residence. Appropriate access includes access to Plan providers when you have traveled outside of the service area. If you are traveling within the service area where other Plan providers are available then you must use Plan providers.

Here are some other things you should know about specialty care:

- If you need to see a specialist frequently because of a chronic, complex, or serious medical condition, you may directly access the specialist for needed services.

- If you are seeing a specialist when you enroll in our Plan, talk to your primary care physician. Your primary care physician will decide what treatment you need. If he or she decides to refer you to a specialist, ask if you can see your current specialist. If your current specialist does not participate with us, you must receive treatment from a specialist who does. Generally, we will not pay for you to see a specialist who does not participate with our Plan.
- If you are seeing a specialist and your specialist leaves the Plan, call your primary care physician, who will arrange for you to see another specialist. You may receive services from your current specialist until we can make arrangements for you to see someone else.
- If you have a chronic and disabling condition and lose access to your specialist because we:
 - Terminate our contract with your specialist for other than cause; or
 - Drop out of the Federal Employees Health Benefits (FEHB) Program and you enroll in another FEHB program Plan; or
 - Reduce our service area and you enroll in another FEHB Plan, you may be able to continue seeing your specialist for up to 90 days after you receive notice of the change. Contact us, or if we drop out of the Program, contact your new plan.
- If you are in the second or third trimester of pregnancy and you lose access to your specialist based on the above circumstances, you can continue to see your specialist until the end of your postpartum care, even if it is beyond the 90 days.

• **Hospital care**

Your Plan primary care physician or specialist will make necessary hospital arrangements and supervise your care. This includes admission to a skilled nursing or other type of facility.

If you are in the hospital when your enrollment in our Plan begins, call our Member Service department immediately at (605) 328-6800 or 1-800-752-5863. If you are new to the FEHB Program, we will arrange for you to receive care.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

• **If you are hospitalized when your enrollment begins**

We pay for covered services from the effective date of your enrollment. However, if you are in the hospital when your enrollment in our Plan begins, call our Member Service department immediately at (605) 328-6800 or 1-800-752-5863. If you are new to the FEHB Program, we will arrange for you to receive care and provide benefits for your covered services while you are in the hospital beginning on the effective date of your coverage.

If you changed from another FEHB plan to us, your former plan will pay for the hospital stay until:

- You are discharged, not merely moved to an alternative care center; or
- The day your benefits from your former plan run out; or
- The 92nd day after you become a member of this Plan, whichever happens first.

These provisions apply only to the benefits of the hospitalized person. If your plan terminates participation in the FEHB Program in whole or in part, or if OPM orders an enrollment change, this continuation of coverage provision does not apply. In such case, the hospitalized family member's benefits under the new plan begin on the effective date of enrollment.

Services requiring our prior approval

You are ultimately responsible for obtaining Prior Approval from the Health Services Department in order to receive In-Network coverage. However, information provided by the provider's office will also satisfy this requirement. Primary care physicians and any Participating Specialists have been given instructions on how to get the necessary authorizations for surgical procedures or hospitalizations you may need.

We determine approval for Prior Approval based on appropriateness of care and service and existence of coverage.

Services that Require Prior Approval Include:

- Inpatient hospital admissions including admissions for medical, surgical, neonatal intensive care nursery, mental health and chemical dependency services;
- Partial Hospital Program (PHP)/Day Treatment for mental health and chemical dependency services;
- Outpatient Surgeries;
- Covered dental procedures;
- Home Health, Hospice and Home IV therapy services;
- Some Durable Medical Equipment;
- One-to-one water therapy;
- Skilled nursing and sub-acute care;
- Transplant Services;
- PET Scans;
- Growth Hormone Therapy;
- Ambulance Services for non-emergency situations; and
- Referrals to Non-Participating Providers which are recommended by Participating Providers.

• How to precertify an admission

Prior Approval is required for the purposes of receiving In-Network coverage for referrals to Non-Participating Providers which are recommended by Participating Providers.

If Prior Approval is not obtained for referrals to Non-Participating Providers, the services will be covered at the Out of Network coverage level. Prior Approval does not apply to services that are provided by Non-Participating Providers as a result of a lack of appropriate access to Participating Providers.

To receive detailed instructions on the Prior Approval process for referrals to Non-Participating Providers, elective inpatient hospitalizations, non urgent care, pharmaceutical decisions, behavioral health, concurrent review and retrospective review (post-service) contact our Health Services Department, available between the hours of 8:00am and 5:00pm Central Standard Time, Monday through Friday, by calling our toll-free number 1-800-805-7938 or (605)328-6807. After hours you may leave a message on the confidential voice mail of the Health Services Department and someone will return your call.

You are ultimately responsible for obtaining Prior Approval from the Health Services Department. Failure to obtain Prior Approval will result in a reduction to the Out of Network benefits level. However, information provided by the physician's office also satisfies this requirement.

Section 4. Your costs for covered services

This is what you will pay out-of-pocket for covered care.

Cost-sharing Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.

Copayments A copayment is a fixed amount of money you pay to the provider, facility, pharmacy, etc., when you receive services.

Example: Under **High Option**, your office visit copayment per visit is \$20 for primary care physicians and \$30 for Specialist. Under **Standard Option**, office visit copayments are \$25 per visit.

Deductible A deductible is a fixed expense you must incur for certain covered services and supplies before we start paying benefits for them.

Example: Under **High Option**, deductibles only apply when you use our Point of Services (POS) benefits. There is a \$500 deductible for Self enrollment and a \$1,000 deductible for Self and Family enrollment. Under **Standard Option**, deductibles apply to both Participating providers and POS benefits. The deductible for Participating provider benefits is \$500 Self enrollment and \$1,000 Self and Family. The POS benefit deductible is \$1,000 Self enrollment and \$3,000 Self and Family.

Note: If you change plans during open season, you do not have to start a new deductible under your old plan between January 1 and the effective date of your new plan. If you change plans at another time during the year, you must begin a new deductible under your new plan.

If you change options in this Plan during the year, we will credit the amount of covered expenses already applied toward the deductible of your old option to the deductible of your new option.

Coinsurance Coinsurance is the percentage of our negotiated fee that you must pay for certain in-network and all out-of-network care. Coinsurance doesn't begin until you meet your deductible (there is no deductible for in-network care under the High Option).

Example: Under **High Option**, you pay 40% of our allowance for medical office visits when you receive services from a Non-Participating Provider or you pay 20% of our negotiated fee for durable medical equipment and orthopedic appliances received by in-network providers. Under **Standard Option**, you pay 20% of our allowance for outpatient surgery when you receive services from Participating Providers or you pay 40% of our allowance for medical office visits when you receive services from non-Participating Providers with POS benefits.

Your catastrophic protection out-of-pocket maximum Under the **High Option**, after your in-network copayments total \$4,000 Self enrollment or \$4,000 Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. Under the **Standard Option**, after your in-network copayments and coinsurances total \$3,000 Self enrollment or \$4,000 Self and Family enrollment in any calendar year, you do not have to pay any more for covered services. However, copayments for the following services do not count toward your catastrophic protection out-of-pocket maximum, and you must continue to pay copayments for these services:

- Prescription drugs; and
- Physician office visits.

Be sure to keep accurate records of your copayments, deductibles and coinsurance since you are responsible for informing us when you reach the maximum.

**When Government
Facilities Bill Us**

Facilities of the Department Government Affairs, the Department of Defense and the Indian Health Services are entitled to seek reimbursement from for certain services and supplies they provide to you or a family member. They may not seek more than the governing laws allow.

Section 5. High and Standard Option Benefits

See page 8 for how our benefits changed this year. Page 66 and page 68 are a benefits summary of each option. Make sure that you review the benefits that are available under the option in which you are enrolled.

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Summary of benefits for the Standard Option of Sanford Health Plan - 200968

Section 5. High and Standard Option Benefits Overview

This plan offers both a High and Standard Option. Our benefit package is described in Section 5. Make sure that you review the benefits carefully.

The High and Standard Option Section 5 is divided into subsections. Please read the *Important things you should keep in mind* at the beginning of the subsections. Also, read the General Exclusions in Section 6, they apply to the benefits in the following subsections. To obtain claim forms, claims filing advice, or more information about our benefits, contact us at 1-800-752-5863 or at our website, www.sanfordhealthplan.com.

High Option

No in-network deductible.

Office visit copay of \$20 for a primary care visit (PCP) and \$30 for a specialty care visit.

There is a \$4,000 out-of-pocket maximum for self only and \$4,000 for self and family enrollment per year.

Standard Option

In-network deductible is \$500 for self only and \$1,000 for self and family enrollment per year.

Office copay of \$25 for both primary care and specialty care visits.

There is a 20% in-network coinsurance for family planning and infertility services, treatment therapies, physical, cardiac, speech, and occupational therapies, orthopedic and prosthetic devices, home health services, acupuncture, outpatient surgical procedures, anesthesia, skilled nursing care, and ambulance services.

There is a \$3,000 out-of-pocket maximum for self only and \$4,000 for self and family enrollment per year.

**Section 5(a). Medical services and supplies
provided by physicians and other health care professionals**

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for In Network services is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive In Network benefit coverage.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Benefit Description	You pay	
	High Option	Standard Option
Diagnostic and treatment services		
Professional services of physicians, nurse practitioners, and physician's assistants	\$20 copay per primary care visit \$30 copay per specialist visit	\$25 copay primary or specialist per visit (No deductible)
<ul style="list-style-type: none"> • In physician's office • Office medical consultations • Second surgical opinion 		
<ul style="list-style-type: none"> • In an urgent care center 	\$20 copay per visit	\$25 copay per visit
<ul style="list-style-type: none"> • During a hospital stay • In a skilled nursing facility • Home visits 	Nothing	Nothing
Lab, X-ray and other diagnostic tests		
Tests, such as:	Nothing if you receive these services during your office visit	20% of charges
<ul style="list-style-type: none"> • Blood tests • Urinalysis • Non-routine Pap tests • Pathology • X-rays • Non-routine mammograms • CAT Scans/MRI • Ultrasound • Electrocardiogram and EEG • PET Scans (See <i>Services requiring our prior approval</i>) 		
<i>Not covered: Virtual colonoscopies</i>	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
Preventive care, adult		
Routine history and physical every year Routine screenings, such as: Total Blood Cholesterol – lipid profile between ages 18-24, once every five years between ages 25-44 and once every year ages 45 and over Colorectal Cancer Screening, including: <ul style="list-style-type: none"> • Fecal occult blood test • Sigmoidoscopy, screening – every five years starting at age 50 • Double contrast barium enema – every five years starting at age 50 • Colonoscopy screening – every ten years starting at age 50 	Nothing	\$25 copay per visit (No deductible)
Routine Prostate Specific Antigen (PSA) test – one annually for men age 40 and older	Nothing	\$25 copay per visit (No deductible)
Routine Pap test Note: You do not pay a separate copay for a Pap test performed during your routine annual physical; see <i>Diagnostic and treatment services</i> .	Nothing	\$25 copay per visit (No deductible)
Routine mammogram – covered for women age 35 and older, as follows: <ul style="list-style-type: none"> • From age 35 through 39, one during this five year period • From age 40 through 64, one every calendar year • At age 65 and older, one every two consecutive calendar years 	Nothing	Nothing
Adult routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC)	Nothing	Nothing
<i>Not covered: Physical exams and immunizations required for obtaining or continuing employment or insurance, attending schools or camp, or travel.</i>	<i>All charges</i>	<i>All charges</i>
Preventive care, children		
<ul style="list-style-type: none"> • Childhood immunizations recommended by the American Academy of Pediatrics • Well-child care charges for routine examinations, immunizations and care (up to age 22) 	Nothing	Nothing
<ul style="list-style-type: none"> • Examinations, such as: <ul style="list-style-type: none"> - Eye exams through age 17 to determine the need for vision correction - Ear exams through age 17 to determine the need for hearing correction 	\$20 copay per primary care visit \$30 copay per specialist visit	\$25 copay per visit (No deductible)

Benefit Description	You pay	
	High Option	Standard Option
<p>Maternity care</p> <p>Complete maternity (obstetrical) care, such as:</p> <ul style="list-style-type: none"> • Prenatal care • Delivery • Postnatal care <p>Note: Here are some things to keep in mind:</p> <ul style="list-style-type: none"> • You do not need to precertify your normal delivery; however, we encourage you to participate in our Healthy Pregnancy Program; see <i>Special Features Section</i>. • You may remain in the hospital up to 48 hours after a regular delivery and 96 hours after a cesarean delivery. We will extend your inpatient stay if medically necessary. • We cover routine nursery care of the newborn child during the covered portion of the mother's maternity stay. We will cover other care of an infant who requires non-routine treatment only if we cover the infant under a Self and Family enrollment. Surgical benefits, not maternity benefits apply to circumcision. <p>Note: Adopted newborns' delivery and nursery charges are covered upon commencement of the legal adoption bonding period.</p> <ul style="list-style-type: none"> • We cover up to 2 routine sonograms per pregnancy to determine fetal age, size or sex. • We pay hospitalization and surgeon services (delivery) the same as for illness and injury. See Hospital benefits (Section 5c) and Surgery benefits (Section 5b). 	Nothing	Nothing
<p>Family planning</p> <p>A range of voluntary family planning services, limited to:</p> <ul style="list-style-type: none"> • Surgically implanted contraceptives • Injectable contraceptive drugs (such as Depo provera) • Intrauterine devices (IUDs) • Diaphragms <p>Note: We cover oral contraceptives under the prescription drug benefit.</p>	<p>\$20 copay per primary care visit</p> <p>\$30 copay per specialist visit</p> <p>20% of charges per inpatient admission</p> <p>\$50 per outpatient surgery</p>	20% of charges
<p>Voluntary Sterilization</p> <p>Note: We pay voluntary sterilization performed secondary to a Cesarean section under See Section 5 (b), <i>Surgical procedures</i>.</p>	20% of charges per inpatient admission	20% of charges

Benefit Description	You pay	
Family planning (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Reversal of voluntary surgical sterilization • Genetic counseling 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Infertility services	High Option	Standard Option
<p>Diagnosis and treatment of infertility such as:</p> <ul style="list-style-type: none"> • Artificial insemination: <ul style="list-style-type: none"> - intravaginal insemination (IVI) - intracervical insemination (ICI) - intrauterine insemination (IUI) 	<p>\$30 per specialist visit</p> <p>20% of charges per inpatient admission</p> <p>\$50 per outpatient surgery</p>	<p>20% of charges</p>
<p><i>Not covered:</i></p> <p><i>Assisted reproductive technology (ART) procedures, such as:</i></p> <ul style="list-style-type: none"> • <i>in vitro fertilization</i> • <i>embryo transfer, gamete intra-fallopian transfer (GIFT) and zygote intra-fallopian transfer (ZIFT)</i> • <i>Services and supplies related to ART procedures</i> • <i>Cost of donor sperm</i> • <i>Cost of donor egg</i> • <i>Fertility drugs</i> • <i>Expenses related to surrogate parenting</i> • <i>Other preservation techniques</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Allergy care	High Option	Standard Option
<ul style="list-style-type: none"> • Testing and treatment • Allergy injections 	<p>\$30 per specialist visit</p>	<p>\$25 copay per visit (No deductible)</p>
<p>Allergy Serum</p>	<p>Nothing</p>	<p>Nothing</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Provocative food testing</i> • <i>Sublingual allergy desensitization</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
Treatment therapies	High Option	Standard Option
<ul style="list-style-type: none"> • Chemotherapy and radiation therapy <p>Note: High dose chemotherapy in association with autologous bone marrow transplants is limited to those transplants listed under <i>Organ/Tissue Transplants in Section 5(b)</i>.</p> <ul style="list-style-type: none"> • Respiratory and inhalation therapy • Dialysis – hemodialysis and peritoneal dialysis • Intravenous (IV)/Infusion Therapy – Home IV and antibiotic therapy • Growth hormone therapy (GHT) 	<p>\$30 per specialist visit</p>	<p>20% of charges</p>

Treatment therapies - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
<p>Treatment therapies (cont.)</p> <p>Note: Growth hormone is covered under the medical benefit.</p> <p>Note: – We only cover GHT when we preauthorize the treatment. We will ask you to submit information that establishes that the GHT is medically necessary. Ask us to authorize GHT before you begin treatment; otherwise, we will only cover GHT services from the date you submit the information. If you do not ask or if we determine GHT is not medically necessary, we will not cover the GHT or related services and supplies. See <i>Services requiring our prior approval</i> in Section 3.</p>	\$30 per specialist visit	20% of charges
<p>Physical and occupational therapies</p> <p>Coverage up to 2 consecutive months per condition for the services of each of the following:</p> <ul style="list-style-type: none"> • qualified physical therapists and • occupational therapists <p>Note: We only cover therapy to restore bodily function when there has been a total or partial loss of bodily function due to illness or injury (see <i>Services requiring our Prior Approval in Section 3</i>).</p> <ul style="list-style-type: none"> • Cardiac rehabilitation following a heart transplant, bypass surgery or a myocardial infarction 	<p>\$30 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Long-term rehabilitative therapy • Exercise programs 	<i>All charges</i>	<i>All charges</i>
<p>Speech therapy</p> <p>Coverage up to 2 consecutive months per condition by speech therapists (see <i>Services requiring our Prior Approval in Section 3</i>).</p>	<p>\$30 per outpatient visit</p> <p>Nothing per visit during covered inpatient admission</p>	20% of charges
<p>Hearing services (testing, treatment, and supplies)</p> <ul style="list-style-type: none"> • First hearing aid(s) (unilateral or bilateral, one time only) and testing and fitting of hearing aid(s) only when necessitated by accidental injury <p>Note: Hearing services must be received within 6 months of injury.</p> <ul style="list-style-type: none"> • Hearing testing for children through age 17 (see <i>Preventive care, children</i>) 	\$30 per specialist visit	\$25 copay per visit (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • All other hearing testing • Hearing aids, testing and examinations for them • All other hearing supplies and services 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
	High Option	Standard Option
<p>Vision services (testing, treatment, and supplies)</p> <ul style="list-style-type: none"> One pair of eyeglasses or contact lenses to correct an impairment directly caused by accidental ocular injury or intraocular surgery (such as for cataracts) Annual eye exam including refraction error to determine the need for vision correction for children through age 17 <p>Note: See <i>Preventive care, children</i> for eye exams for children.</p>	<p>\$20 per primary care visit \$30 per specialist visit</p>	<p>\$25 copay per visit (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Eyeglasses or contact lenses, except as shown above</i> <i>Surgery for the purpose of modifying or correcting myopia, hyperopia or stigmatic error</i> <i>All other vision services except as described above</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Foot care</p> <p>Routine foot care when you are under active treatment for a metabolic or peripheral vascular disease, such as diabetes.</p> <p>Note: See <i>Orthopedic and prosthetic devices</i> for information on podiatric shoe inserts.</p>	<p>\$20 per primary care visit \$30 per specialist</p>	<p>\$25 copay per visit (No deductible)</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Cutting, trimming or removal of corns, calluses, or the free edge of toenails, and similar routine treatment of conditions of the foot, except as stated above</i> <i>Treatment of weak, strained or flat feet or bunions or spurs; and of any instability, imbalance or subluxation of the foot (unless the treatment is by open cutting surgery)</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>
<p>Orthopedic and prosthetic devices</p> <ul style="list-style-type: none"> Custom diabetic shoes and inserts limited to <i>one (1)</i> pair of depth-inlay shoes and <i>three (3)</i> pairs of inserts; or <i>one (1)</i> pair of custom molded shoes (including inserts) and <i>two (2)</i> additional pairs of inserts Artificial limbs and eyes; stump hose Externally worn breast prostheses and surgical bras, including necessary replacements following a mastectomy. Includes 2 external prosthesis per calendar year and 2 bras per calendar year. For double mastectomy, coverage extends to 4 external prosthesis per calendar year and 2 bras per calendar year. 	<p>20% of charges</p>	<p>20% of charges</p>

Orthopedic and prosthetic devices - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
<p>Orthopedic and prosthetic devices (cont.)</p> <ul style="list-style-type: none"> Internal prosthetic devices, such as artificial joints, pacemakers, cochlear implants, and surgically implanted breast implant following mastectomy. Note: Internal prosthetic devices are paid as hospital benefits; see <i>Section 5(c)</i> for payment information. Insertion of the device is paid as surgery; see <i>Section 5(b)</i> for coverage of the surgery to insert the device. Corrective orthopedic appliances for non-dental treatment of temporomandibular joint (TMJ) pain dysfunction syndrome. (See <i>Services requiring our prior approval</i> in Section 3.) 	20% of charges	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Orthopedic and corrective shoes (except as covered under the diabetic benefit)</i> <i>Shoe inserts (except as covered under the diabetic benefit)</i> <i>Arch supports</i> <i>Foot orthotics (except as covered under the diabetic benefit)</i> <i>Heel pads and heel cups</i> <i>Lumbosacral supports</i> <i>Corsets, trusses, elastic stockings, support hose, and other supportive devices</i> <i>Prosthetic replacements provided prior to expiration of the manufacturers life expectancy of the prosthetic. Policy guidelines apply.</i> <i>Dental appliances of any sort, including but not limited to bridges, braces, and retainers, except those for non-dental treatment of TMJ</i> <i>Wigs, scalp hair prosthesis or hair transplants</i> <i>Cleaning and polishing of prosthetic eye(s)</i> 	<i>All charges</i>	<i>All charges</i>
<p>Durable medical equipment (DME)</p> <p>Rental or purchase, at our option, including repairs (repairs are limited to \$750 allowable charges per year) and adjustments, of durable medical equipment prescribed by your Plan physician, such as oxygen and dialysis equipment.</p> <p>Under this benefit, we also cover:</p> <ul style="list-style-type: none"> standard hospital beds; standard wheelchairs; crutches; walkers; canes; 	<p>20% of charges</p> <p>Note: You must obtain prior-authorization for the following supplies/equipment. Failure to obtain Prior Approval will result in benefits being paid at the Point of Service benefit level.</p>	<p>20% of charges</p> <p>Note: You must obtain prior-authorization for the following supplies/equipment. Failure to obtain Prior Approval will result in benefits being paid at the Point of Service benefit level.</p>

Durable medical equipment (DME) - continued on next page

Benefit Description	You pay	
Durable medical equipment (DME) (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • diabetes supplies including blood glucose monitors and insulin pumps; • spacers; • initial casts, braces, and/or slings provided on day of treatment; • air compressor; • pressure pads, mattresses, and decubitus care equipment; • apnea monitor; • sleeve compression; • home intravenous therapy supplies; • commodes; and • compression hose. <p>Note: We will cover motorized wheelchairs and electric beds up to, but not to exceed, the cost of standard wheelchairs or standard hospital beds. Limited to one per lifetime. Call us at (605) 328-6807 or toll free at 1-800-805-7938 as soon as your Plan physician prescribes this equipment. We will arrange with a health care provider to rent or sell you durable medical equipment at discounted rates and will tell you more about this service when you call.</p>	<p>20% of charges</p> <p>Note: You must obtain prior-authorization for the following supplies/equipment. Failure to obtain Prior Approval will result in benefits being paid at the Point of Service benefit level.</p>	<p>20% of charges</p> <p>Note: You must obtain prior-authorization for the following supplies/equipment. Failure to obtain Prior Approval will result in benefits being paid at the Point of Service benefit level.</p>
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Medical supplies/equipment that can be purchased over-the-counter</i> • <i>Household equipment/fixtures, such as air purifiers and ramps</i> • <i>Convenience items</i> • <i>Self-help items</i> • <i>Educational equipment</i> • <i>Communication aids or devices, such as speech processors</i> • <i>Replacement or repair of items, if the items are damaged or destroyed by your misuse, abuse or carelessness, lost, or stolen</i> • <i>Duplicate or similar items</i> • <i>Service call charges, labor charges, charges for repair estimates</i> • <i>Vehicle/car or van modifications including, but not limited to, hand brakes, hydraulic lifts and car carrier</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Benefit Description	You pay	
	High Option	Standard Option
<p>Home health services</p> <ul style="list-style-type: none"> Home health care ordered by a Plan physician and provided by a registered nurse (R.N.), licensed practical nurse (L.P.N.), licensed vocational nurse (L.V.N.), or home health aide. Services include oxygen therapy, intravenous therapy and medications. <p>Note: One home health visit constitutes 4 hours of nursing care. Prior approval is required; failure to get prior approval will result in payment at the point of service level (See <i>Services requiring our prior approval</i> in Section 3).</p>	\$20 copay per visit	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Nursing care requested by, or for the convenience of, the patient or the patient's family;</i> <i>Home care primarily for personal assistance that does not include a medical component and is not diagnostic, therapeutic, or rehabilitative.</i> 	<i>All charges</i>	<i>All charges</i>
<p>Chiropractic</p> <ul style="list-style-type: none"> Manipulation of the spine and extremities Adjunctive procedures such as ultrasound, electrical muscle stimulation, and vibratory therapy <p>Note: Office visits are limited to 20 visits per calendar year.</p>	\$20 copay per visit	\$25 copay per visit (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Vitamins, minerals, therabands, cervical pillows, traction services, and hot/cold pack application.</i> 	<i>All charges</i>	<i>All charges</i>
<p>Alternative treatments</p> <ul style="list-style-type: none"> Acupuncture – by a doctor of medicine or osteopathy for: anesthesia, pain relief Sleep therapy for central of obstructive apnea when we have approved it 	\$30 per specialist visit	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> <i>Homeopathic or Naturopathic services</i> <i>Hypnotherapy</i> <i>Biofeedback</i> 	<i>All charges</i>	<i>All charges</i>

Benefit Description	You pay	
Educational classes and programs	High Option	Standard Option
<p>Coverage is limited to:</p> <ul style="list-style-type: none"> • Smoking Cessation – Up to \$100 for one smoking cessation program per member per lifetime, including all related expenses such as prescription drugs • Diabetes self management from qualified providers for persons who meet plan criteria – limited to no more than two (2) comprehensive education programs per lifetime and up to eight (8) follow-up visits per year will be covered. 	Nothing	Nothing

Section 5(b). Surgical and anesthesia services provided by physicians and other health care professionals

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option** The calendar year deductible is: \$500 per person (\$1000 per family). The calendar year deductible applies to almost all benefits in this Section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive in-network benefit coverage.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by a physician or other health care professional for your surgical care. Look in Section 5(c) for charges associated with the facility (i.e. hospital, surgical center, etc.).
- **YOU OR YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR SOME SURGICAL PROCEDURES.** Please refer to the prior approval information shown in Section 3 to be sure which services require prior approval and identify which surgeries require precertification.

Benefit Description	You pay	
	High Option	Standard Option
Surgical procedures A comprehensive range of services, such as: <ul style="list-style-type: none"> • Operative procedures • Treatment of fractures, including casting • Normal pre- and post-operative care by the surgeon • Correction of amblyopia and strabismus • Endoscopy procedures • Biopsy procedures • Removal of tumors and cysts • Correction of congenital anomalies (see <i>Reconstructive surgery</i>) • Surgical treatment of morbid obesity (bariatric surgery) You must meet the following criteria before the surgery can be authorized: <ul style="list-style-type: none"> - Psychiatrist or Psychologist psychiatric evaluation prior to medical review - Body Mass Index (BMI) greater than 40 - Have tried other weight loss options without success - Age twenty-one (21) 	\$30 per specialist visit	\$25 copay per office visit (No deductible)

Surgical procedures - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
<p>Surgical procedures (cont.)</p> <ul style="list-style-type: none"> - One (1) year of documented attendance in a Plan approved weight loss or bariatric program with only three (3) <u>excused</u> absences and with demonstrated failure to lose weight <p>Note: Contact Health Services for additional information at (605) 328-6807 or 1-800-805-7938.</p> <ul style="list-style-type: none"> • Insertion of internal prosthetic devices . See 5(a) – <i>Orthopedic and prosthetic devices</i> for device coverage information <p>Note: Generally, we pay for internal prostheses (devices) according to where the procedure is done. For example, we pay Hospital benefits for a pacemaker and Surgery benefits for insertion of the pacemaker.</p> <ul style="list-style-type: none"> • Voluntary sterilization (e.g., tubal ligation, vasectomy) • Treatment of burns 	\$30 per specialist visit	\$25 copay per office visit (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Reversal of voluntary sterilization</i> 	<i>All charges</i>	<i>All charges</i>
<p>Reconstructive surgery</p> <ul style="list-style-type: none"> • Surgery to correct a functional defect • Surgery to correct a condition caused by injury or illness if: <ul style="list-style-type: none"> - the condition produced a major effect on the member's appearance and - the condition can reasonably be expected to be corrected by such surgery • Surgery to correct a condition that existed at or from birth and is a significant deviation from the common form or norm. Examples of congenital anomalies are: protruding ear deformities, cleft lip, cleft palate, birth marks, and webbed fingers and toes • All stages of breast reconstruction surgery following a mastectomy, such as: <ul style="list-style-type: none"> - surgery to produce a symmetrical appearance of breasts; - treatment of any physical complications such as lymphedemas; - breast prostheses and surgical bras and replacements (see Prosthetic devices) 	\$30 per specialist visit	\$25 copay per office visit (No deductible)

Reconstructive surgery - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Reconstructive surgery (cont.)		
Note: If you need a mastectomy, you may choose to have the procedure performed on an inpatient basis and remain in the hospital up to 48 hours after the procedure.	\$30 per specialist visit	\$25 copay per office visit (No deductible)
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<ul style="list-style-type: none"> • <i>Cosmetic surgery – any surgical procedure (or any portion of a procedure) performed primarily to improve physical appearance through change in bodily form, including skin tag removal, except repair of accidental injury</i> • <i>Surgeries related to sex transformation</i> 		
Oral and maxillofacial surgery	High Option	Standard Option
Oral surgical procedures, limited to:	\$30 per specialist visit	\$25 copay per visit (No deductible)
<ul style="list-style-type: none"> • Reduction of fractures of the jaws or facial bones; • Surgical correction of cleft lip, cleft palate or severe functional malocclusion; • Removal of stones from salivary ducts; • Excision of leukoplakia or malignancies; • Excision of cysts and incision of abscesses when done as independent procedures; • Other surgical procedures that do not involve the teeth or their supporting structures; and • Surgery to correct TMJ is covered upon radiological determination of pathology (See <i>Services requiring our prior approval</i> in Section 3) 		
<i>Not covered:</i>	<i>All charges</i>	<i>All charges</i>
<ul style="list-style-type: none"> • <i>Oral implants and transplants</i> • <i>Procedures that involve the teeth or their supporting structures (such as the periodontal membrane, gingiva, and alveolar bone)</i> 		
Organ/tissue transplants	High Option	Standard Option
Solid organ transplants are subject to medical necessity and experimental/investigational review. Refer to <i>Other services</i> in Section 3 for prior authorization procedures. The medical necessity limitation is considered satisfied for other tissue transplants if the patient meets the staging description.	Nothing	Nothing
<ul style="list-style-type: none"> • Cornea • Heart • Heart/lung • Kidney • Kidney/pancreas • Liver 		

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Intestinal transplants <ul style="list-style-type: none"> - Small intestine - Small intestine with the liver - Small intestine with multiple organs, such as the liver, stomach and pancreas 	Nothing	Nothing
<ul style="list-style-type: none"> • Lung: single, double or lobar lung • Pancreas <p>Blood or marrow stem cell transplants limited to the stages of the following diagnoses: (The medical necessity limitation is considered satisfied if the patient meets the staging description.)</p> <ul style="list-style-type: none"> • Allogenic transplants for: <ul style="list-style-type: none"> - Acute or chronic lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Burkitt's lymphoma for adolescents and young adults - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Chronic myelogenous leukemia - Hemoglobinopathy (i.e. Fanconi's, Thalessemia major) - Myelodysplasia/Myelodysplastic syndromes - Severe combined immunodeficiency - Severe or very severe aplastic anemia - Amyloidosis • Autologous transplant for: <ul style="list-style-type: none"> - Acute lymphocytic or nonlymphocytic (i.e., myelogenous) leukemia - Advanced Hodgkin's lymphoma - Advanced non-Hodgkin's lymphoma - Neuroblastoma - Amyloidosis • Autologous tandem transplants for: <ul style="list-style-type: none"> - Recurrent germ cell tumors (including testicular cancer) - Multiple myeloma - De-novo myeloma <p>Blood or marrow stem cell transplants for:</p> <ul style="list-style-type: none"> • Allogenic transplants for <ul style="list-style-type: none"> - Phagocytic/Hemophagocytic deficiency diseases (e.g., Wiskott-Aldrich syndrome) - Advanced neuroblastoma 	Nothing	20% of charges

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Infantile malignant osteopetrosis - Kostmann’s syndrome - Leukocyte adhesion deficiencies - Mucopolipidosis (e.g., Gaucher’s disease, metachromatic leukodystrophy, adrenoleukodystrophy) - Mucopolysaccharidosis (e.g., Hunter’s syndrome, Hurler’s syndrome, Sanfilippo’s syndrome, Maroteaux-Lamy syndrome variants) - Myeloproliferative disorders - Sickle cell anemia 	Nothing	20% of charges
<p>Autologous transplants for:</p> <ul style="list-style-type: none"> • Multiple myeloma • Testicular, mediastinal, retroperitoneal, and ovarian germ cell tumors • Breast cancer • Epithelial ovarian cancer • Ependymoblastoma • Ewing's sarcoma • Medulloblastoma • Pineoblastoma • Waldenstrom’s macroglobulinemia 	Nothing	20% of charges
<p>Mini-transplants (non-myeloblastic, reduced intensity conditioning): Subject to medical necessity.</p>		
<p>Tandem transplants: Subject to medical necessity.</p>		
<p>Blood or marrow stem cell transplants covered only in a National Cancer Institute or National Institutes of Health approved clinical trial at a Plan-designated center of excellence and if approved by the Plan’s medical director in accordance with the Plan’s protocols for:</p> <ul style="list-style-type: none"> • Allogenic transplants for <ul style="list-style-type: none"> - Multiple myeloma - Chronic lymphocytic leukemia - Chronic lymphocytic leukemia/small lymphocytic lymphoma (CLL/SLL) - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Myelodysplasia/Myelodysplastic syndromes - Multiple sclerosis • Nonmyeloablative allogenic transplants for 		

Organ/tissue transplants - continued on next page

Benefit Description	You pay	
Organ/tissue transplants (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> - Acute lymphocytic or non-lymphocytic (i.e., myelogenous) leukemia - Myelodysplasia/myelodysplastic syndromes - Advanced Hodgkin’s lymphoma - Advanced non-Hodgkin’s lymphoma - Breast cancer - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Colon cancer - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Multiple myeloma - Multiple sclerosis • Autologous transplants for <ul style="list-style-type: none"> - Chronic myelogenous leukemia - Chronic lymphocytic leukemia - Chronic myelogenous leukemia - Early stage (indolent or non-advanced) small cell lymphocytic lymphoma - Chronic lymphocytic lymphoma/small lymphocytic lymphoma (CLL/SLL) - Small cell lung cancer • National Transplant Program <p>Note: We cover related medical and hospital expenses of the donor when we cover the recipient and when they are not covered by another Group health plan or other coverage arrangement. All transplants must be provided at Plan participating Center of Excellence facilities.</p>	Nothing	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Donor screening tests and donor search expenses, except those performed for the actual donor</i> • <i>Harvesting and storage of stem cells</i> • <i>Implants of artificial organs</i> • <i>Transplants not listed as covered</i> • <i>Transplant evaluations that do not meet the United Network for Organ Sharing (UNOS) criteria</i> 	<i>All charges</i>	<i>All charges</i>

High and Standard Option

Benefit Description	You pay	
Anesthesia	High Option	Standard Option
Professional services provided in – • Hospital (inpatient)	Nothing	20% of charges
Professional services provided in – • Hospital outpatient department • Skilled nursing facility • Ambulatory surgical center • Office	Nothing	20% of charges
<i>Not covered: Hypnotic anesthesia</i>	<i>All charges</i>	<i>All charges</i>

Section 5(c). Services provided by a hospital or other facility, and ambulance services

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- Plan physicians must provide or arrange your care and you must be hospitalized in a Plan facility.
- **Under High Option**, we have no calendar year deductible for In-Network services.
- **Under Standard Option**, the calendar year deductible for Participating Providers is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive in-network benefit coverage.
- Be sure to read Section 4, *Your costs for covered services* for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- The amounts listed below are for the charges billed by the facility (i.e., hospital or surgical center) or ambulance service for your surgery or care. Any costs associated with the professional charge (i.e., physicians, etc.) are in Sections 5(a) or (b).
- **YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR HOSPITAL STAYS.** Please refer to Section 3 to be sure which services require prior approval.

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital Room and board, such as <ul style="list-style-type: none"> • Ward, semiprivate, or intensive care accommodations; • General nursing care; and • Meals and special diets. Note: If you want a private room when it is not medically necessary, you pay the additional charge above the semiprivate room rate.	\$100 per day copay up to \$500 per admission	\$100 per day copay up to \$500 per admission
Other hospital services and supplies, such as: <ul style="list-style-type: none"> • Operating, recovery, maternity, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests and X-rays • Administration of blood or blood products • Dressings, splints, casts, and sterile tray services • Medical supplies and equipment, including oxygen • Anesthetics, including nurse anesthetist services • Medical supplies, appliances, medical equipment and any covered items billed by a hospital for use at home or take home items 	Nothing	Nothing

Inpatient hospital - continued on next page

Benefit Description	You pay	
	High Option	Standard Option
Inpatient hospital (cont.)		
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Non-covered facilities, such as nursing homes, schools • Personal comfort items, such as telephone, television, barber services, guest meals and beds • Private nursing care • Admissions to hospitals performed only for the convenience of the member, the member's family or the member's physician or other provider 	<i>All charges</i>	<i>All charges</i>
Outpatient hospital or ambulatory surgical center		
<ul style="list-style-type: none"> • Operating, recovery, and other treatment rooms • Prescribed drugs and medicines • Diagnostic laboratory tests, X-rays, and pathology services • Administration of blood, blood plasma, and other biologicals • Blood and blood plasma, if not donated or replaced • Dressings, casts, and sterile tray services • Medical supplies, including oxygen • Anesthetics and anesthesia service <p>Note: We cover hospital services and supplies related to dental procedures when necessitated by a non-dental physical impairment. We do not cover the dental procedures.</p>	\$50 per visit	20% of charges
<p>Outpatient hospital services:</p> <ul style="list-style-type: none"> • Diagnostic laboratory tests, X-rays and pathology services • Pre-surgical testing 	Nothing	20% of charges
<i>Not covered: Blood storage for use at a later date</i>	<i>All charges</i>	<i>All charges</i>
Extended care benefits/Skilled nursing care facility benefits		
<p>Extended care benefit includes all necessary services ordered by a Plan provider including:</p> <ul style="list-style-type: none"> • Unlimited days • Bed, board, and general nursing care • Drugs, biologicals, supplies and equipment ordinarily provided or arranged by the skilled nursing facility when prescribed by a plan provider 	\$100 per day copay up to \$500 per admission	\$100 per day copay up to \$500 per admission

Extended care benefits/Skilled nursing care facility benefits - continued on next page

Benefit Description	You pay	
Extended care benefits/Skilled nursing care facility benefits (cont.)	High Option	Standard Option
Note: Care must be received from a state licensed nursing facility	\$100 per day copay up to \$500 per admission	\$100 per day copay up to \$500 per admission
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Custodial care • Convalescent care • Intermediate level or domiciliary care • Residential care • Rest cures or services to assist in activities of daily living 	<i>All charges</i>	<i>All charges</i>
Hospice care	High Option	Standard Option
<ul style="list-style-type: none"> • Admission to a hospice facility, hospital, or skilled nursing facility for room and board, supplies and services for pain management and other acute/ chronic symptom management • Part-time or intermittent nursing care by an RN, LPN, LVN or home health aide for patient care for up to 8 hours a day • Social services • Psychological and dietary counseling • Physical or occupational therapy • Consultation and case management services by a participating practitioner • Medical supplies and drugs prescribed by a participating practitioner 	Nothing	20% of charges
<i>Not covered: Independent nursing, homemaker services</i>	<i>All charges</i>	<i>All charges</i>
Ambulance	High Option	Standard Option
Local professional ground and/or air ambulance service when medically appropriate and plan approved hospital transfers.	\$50 copay	20% of charges
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • Transfers to hospitals performed only for the convenience of the member, the member's family or the member's physician or other provider. • Non-emergency services and/or travel, unless pre-approved and arranged by us. 	<i>All charges</i>	<i>All charges</i>

Section 5(d). Emergency services/accidents

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for Participating Providers is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive in-network benefit coverage.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

What is a medical emergency? A medical emergency is the sudden and unexpected onset of a condition or an injury that you believe endangers your life or could result in serious injury or disability, and requires immediate medical or surgical care. Some problems are emergencies because, if not treated promptly, they might become more serious; examples include deep cuts and broken bones. Others are emergencies because they are potentially life-threatening, such as heart attacks, strokes, poisonings, gunshot wounds, or sudden inability to breathe. There are many other acute conditions that we may determine are medical emergencies – what they all have in common is the need for quick action.

What to do in case of emergency: In the event of an Emergency Medical Condition, go to the closest emergency room, or call 911 for assistance. We will cover Emergency Services whether you are in or out of the Service Area. Sioux Valley Health Plan offers world-wide emergency coverage. Prior approval for treatment of Emergency Medical Conditions is not required. You should have someone telephone us at 1-800-805-7938 as soon as reasonably possible. **Inpatient or outpatient emergency services that are furnished by any qualified Provider and needed to evaluate or stabilize an Emergency Medical Condition are covered.**

Emergencies within our service area: If you have an Emergency Medical Condition within the Service Area, you should contact your PCP and the Plan after an emergency so that we can arrange for your follow-up care.

Emergencies outside our service area: If you have an Emergency Medical Condition while out of the Service Area, we prefer that you return to the Service Area to receive care through Plan Participating Providers after you have been treated for your condition. However, services will be covered out of the Service Area as long as the care required continues to meet the definition for either Emergency Services or Urgently Needed Services.

Whether you are inside or outside of our service area, \$100 copay for Emergency or Urgent services applies. However, this copay is waived if you are admitted to a hospital as a result of the emergency visit.

Post-Stabilization Care: We also provide coverage for services needed to ensure that you remain stabilized (or, in certain instances, to improve or resolve your condition) if:

- We provide prior approval for such services; or
- The services were not pre-approved by us, but were administered within 1 hour of a request from the Provider for prior approval of additional post-stabilization care; or
- We do not respond within one (1) hour to a request for prior approval from a Non-Contracting Medical Provider or Facility (or we could not be contacted for prior approval).

Coverage for Post-Stabilization Care is effective until:

- You are discharged; or
- A Contracting Medical Provider with privileges at the hospital in which you are treated arrives and assumes responsibility for your care; or

- The Non-Contracting Medical Provider and Sanford Health Plan agree to other arrangements; or
- A Contracting Medical Provider assumes responsibility for your care through transfer.

Remember, if you receive services from Non-Contracting Medical Providers without Prior approval, except for Emergency Services, Urgently Needed Services, or out-of-area renal dialysis, Sanford Health Plan will pay for those services at the Out-of-Network benefit level.

Refunds for Emergency, Urgently Needed, or Out-of-Area Dialysis Services Paid by Members: Providers should submit bills to us for payment. However, if you paid for any Emergency Services, Urgently Needed Services, or Out-of-Area Renal Dialysis services obtained from Non-Contracting Medical Providers, you should submit your bills us to Sanford Health Plan for payment. Bills should be submitted to the following address:

Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. If you have questions about any bills, contact our Member Service Department at 1-800-752-5863 or (605) 328-6800. The hours of operation for these numbers are 8:00am until 5:00pm Central Standard Time, Monday through Friday.

Benefit Description	You pay	
	High Option	Standard Option
Emergency within our service area		
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center 	\$20 per primary care visit \$30 per specialist visit	\$25 copay per primary care or specialist visit (No deductible)
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital, including doctor's services <p>Note: We waive the ER copay if you are admitted to the hospital. However, the inpatient admission copay still applies.</p>	\$100 copay per visit, waived if admitted	\$100 copay per visit, waived if admitted (No deductible)
<i>Not covered: Elective care or non-emergency care</i>	<i>All charges</i>	<i>All charges</i>
Emergency outside our service area		
<ul style="list-style-type: none"> • Emergency care at a doctor's office • Emergency care at an urgent care center 	\$20 per primary care visit \$30 per specialist visit	\$25 copay per primary care or specialist visit (No deductible)
<ul style="list-style-type: none"> • Emergency care as an outpatient at a hospital, including doctors' services <p>Note: We waive the ER copay if you are admitted to the hospital. However, the inpatient admission copay still applies.</p>	\$100 per visit, waived if admitted	\$100 per visit, waived if admitted (No deductible)
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Elective care or non-emergency care and follow-up care recommended by non-Plan providers that has not been approved by the Plan or provided by Plan providers</i> • <i>Emergency care provided outside the service area if the need for care could have been foreseen before leaving the service area</i> • <i>Medical and hospital costs resulting from a normal full-term delivery of a baby outside the service area</i> 	<i>All charges</i>	<i>All charges</i>

High and Standard Option

Benefit Description	You pay	
Ambulance	High Option	Standard Option
Professional ground ambulance, air ambulance, or regularly scheduled flight on a commercial airline when service is medically appropriate. Note: See 5(c) for non-emergency service.	\$50 copay	20% of charges

Section 5(e). Mental health and substance abuse benefits

When you get our approval for services and follow a treatment plan we approve, cost-sharing and limitations for Plan mental health and substance abuse benefits will be no greater than for similar benefits for other illnesses and conditions.

Important things to keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for Participating Providers is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive in-network benefit coverage.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU MUST GET PRIOR APPROVAL FOR THESE SERVICES.** See the instructions after the benefits description below.

Benefit Description	You pay	
	High Option	Standard Option
<p>All diagnostic and treatment services recommended by a Plan provider and contained in a treatment plan that we approve. The treatment plan may include services, drugs, and supplies described elsewhere in this brochure.</p> <p>Note: Plan benefits are payable only when we determine the care is clinically appropriate to treat your condition and only when you receive the care as part of a treatment plan that we approve.</p>	Your cost sharing responsibilities are no greater than for other illnesses or conditions.	Your cost sharing responsibilities are no greater than for other illnesses or conditions.
<ul style="list-style-type: none"> • Outpatient professional services, including individual or group therapy by providers such as psychiatrists, psychologists, or clinical social workers • Medication management 	\$30 per specialist outpatient visit	\$25 per visit (No deductible)
<ul style="list-style-type: none"> • Diagnostic tests 	Nothing	20% of charges
<ul style="list-style-type: none"> • Services provided by a hospital or other facility • Services in approved alternative care settings such as partial hospitalization, half-way house, residential treatment, full-day hospitalization, facility-based intensive outpatient treatment 	\$100 per day copay up to \$500 per inpatient admission	\$100 per day copay up to \$500 per inpatient admission
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Marriage, family, or bereavement counseling</i> • <i>Pastoral counseling</i> • <i>Financial or legal counseling</i> 	<i>All charges</i>	<i>All charges</i>

Mental health and substance abuse benefits - continued on next page

Benefit Description	You pay	
Mental health and substance abuse benefits (cont.)	High Option	Standard Option
<ul style="list-style-type: none"> • Custodial care counseling • Services we have not approved • Long term custodial care <p><i>Note: OPM will base its review of disputes about treatment plans on the treatment plan's clinical appropriateness. OPM will generally not order us to pay or provide one clinically appropriate treatment plan in favor of another.</i></p>	<i>All charges</i>	<i>All charges</i>

Prior Authorization

To be eligible to receive these benefits you must obtain a treatment plan and follow the authorization processes:

Contact our Health Services Department for the prior approval process for elective inpatient hospitalizations, non urgent care, pharmaceutical decisions, behavioral health, urgent/emergency conditions, concurrent review and retrospective review (post-service) contact our Health Services Department, available between the hours of 8:00am and 5:00pm Central Time, Monday through Friday, by calling our toll-free number 1-800-805-7938 or (605) 328-6807. After hours you may leave a message on the confidential voice mail of the Health Services Department and someone will return your call.

You are ultimately responsible for obtaining prior approval from the Health Services Department. Failure to obtain prior approval will result in a reduction to the Out of Network benefits level. However, information provided by the physician's office also satisfies this requirement.

Limitation

We may limit your benefits if you do not obtain a treatment plan.

Section 5(f). Prescription drug benefits

Important things you should keep in mind about these benefits:

- We cover prescribed drugs and medications, as described in the chart beginning on the next page.
- Please remember that all benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for Participating Providers is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers; there are no Point of Service (out-of-network) benefits.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

There are important features you should be aware of. These include:

- **Who can write your prescription.** A plan physician, Nurse Practitioner, Physician's Assistant, or licensed dentist must write the prescription.
- **Where you can obtain them.** You must fill the prescription at a network pharmacy. If you choose to go to a non-network pharmacy, you must pay 100% of the costs of the medication to the pharmacy (except in an emergency). Some injectible drugs are obtained through mail order. For more information call Member Services at (605) 328-6800 for a copy of the Prescription Drug Brochure. To enroll and obtain prior-approval to join the Injectible Drugs Program call 1-800-278-0980.
- **How you can obtain them.** You must present your prescription ID card to your pharmacy, if you do not present your health plan ID card to your pharmacy, you must pay 100% of the costs of the medication to the pharmacy (except in an emergency).
- **We use an open formulary** that has three levels (or tiers):
 - **Level I** is the lowest copay and generally includes generic drugs but may include some brand formulary or preferred brands.
 - **Level II** represents the mid-range copays and generally includes brand formulary and preferred brands, but may include some generics and brands not included in Level I.
 - **Level III** is the highest copay and may include all other covered drugs not on Level II and III, such as non-formulary, or non-preferred drugs and some specialty drugs.

If your physician believes a name brand product is necessary or there is no generic available, your physician may prescribe a name brand drug from a formulary list. This list of name brand drugs is a preferred list of drugs that we selected to meet patient needs at a lower cost. To order a prescription drug brochure, call (605) 328-6800 or 1-800-752-5863 or go to the Express Scripts website at www.sanfordhealthplan.com.

These are the dispensing limitations:

- **Prescriptions can be filled for up to a 30 day supply per copayment.** Those prescription drug classes identified as maintenance medications will be made available for up to a 90-day supply. However, three copayments will apply.
- **A generic equivalent will be dispensed if it is available**, unless your physician specifically requires a name brand. If you receive a name brand drug when a Federally-approved generic drug is available, and your physician has not specified Dispense as Written for the name brand drug, you have to pay the difference in cost between the name brand drug and the generic. Additionally, if there is no generic equivalent, you will still be required to pay the brand name copayment.
- If there is a national emergency or you are called to active military duty, you may call our Member Services Department at (605) 328-6800 to request an exception for dispensing limitations.

Why use generic drugs? To reduce your out-of-pocket expenses! A generic drug is the chemical equivalent of a corresponding brand name drug. Under federal law, generic and name brand drugs must meet the same standards for safety, purity, strength, and effectiveness. Generic drugs are less expensive than brand name drugs; therefore, you may reduce your out-of-pocket costs by choosing to use a generic drug.

When you do have to file a claim. If you fail to use your health plan ID card to purchase prescription drugs, you must submit the claims directly to us at: Sioux Valley Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110. Claim forms are available at your request. You may, however, submit your itemized prescription receipt with date, supply, drug name, and all necessary member information in lieu of a claim form.

Benefit Description	You pay	
	High Option	Standard Option
<p>Covered medications and supplies</p> <p>We cover the following medications and supplies prescribed by a Plan physician and obtained from a Plan pharmacy:</p> <ul style="list-style-type: none"> • Drugs and medicines that by Federal law of the United States require a physician's prescription for their purchase, except those listed as <i>Not covered</i>. • Self administered injectible drugs • Drugs for sexual dysfunction limited per policy guidelines. Contact the Plan for details. Viagra limited to 4 pills per month. (see Section 3, <i>Services requiring our Prior approval</i>) • Contraceptive drugs and devices • Human Growth Hormones (see Section 3, <i>Services requiring our Prior approval</i>) • Prescription drugs for smoking cessation up to a 3-month supply per calendar year 	<p>\$15 per formulary generic drug</p> <p>\$30 per formulary brand name drug</p> <p>\$50 per non-formulary brand name drug.</p> <p>Note: If you request that you receive the brand name drug when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic in addition to your copay.</p>	<p>\$15 per formulary generic drug</p> <p>\$30 per formulary brand name drug</p> <p>\$50 per non-formulary brand name drug.</p> <p>Note: If you request that you receive the brand name drug when there is an equivalent generic alternative available, you will be required to pay the price difference between the brand and the generic in addition to your copay.</p>
<p>Diabetic Drugs/Supplies</p> <ul style="list-style-type: none"> • Insulin vials • Blood glucose monitors • Insulin infusion devices, pumps and all supplies for pump • Prescribed oral agents for controlling blood sugars • Lancets and lancet devices • Blood/urine testing strips (maximum of 200 strips per month supply) • Glucose agents • Glucagon kits • Syringes for the administration of covered medications 	<p>\$15 copay per one month supply for each individual item</p>	<p>\$15 copay per one month supply for each individual item (No deductible)</p>
<p>Insulin Pens, Cartridges & Innolets</p>	<p>\$30 per one month supply</p>	<p>\$30 per one month supply</p>

Covered medications and supplies - continued on next page

Benefit Description	You pay	
Covered medications and supplies (cont.)	High Option	Standard Option
<p><i>Not covered:</i></p> <ul style="list-style-type: none"> • <i>Drugs and supplies for cosmetic purposes including baldness and appetite suppressants</i> • <i>Drugs to enhance athletic performance</i> • <i>Fertility drugs</i> • <i>Drugs obtained at a non-Plan pharmacy; except for out-of-area emergencies</i> • <i>Vitamins, nutrients and food supplements even if a physician prescribes or administers them</i> • <i>Medication available over the counter (OTC)</i> • <i>Orthomolecular therapy including nutrients, vitamins</i> • <i>B-12 injections, except for pernicious anemia</i> • <i>Compound medications with no legend medication</i> • <i>Acne medication for members over age thirty-five</i> • <i>Nonprescription medicines</i> 	<p><i>All charges</i></p>	<p><i>All charges</i></p>

Section 5(g). Special features

Feature	Description
Flexible benefits option	<p>Under the flexible benefits option, we determine the most effective way to provide services.</p> <ul style="list-style-type: none"> • We may identify medically appropriate alternatives to traditional care and coordinate other benefits as a less costly alternative benefit. If we identify a less costly alternative, we will ask you to sign an alternative benefits agreement that will include all of the following terms. Until you sign and return the agreement, regular contract benefits will continue. • Alternative benefits will be made available for a limited time period and are subject to our ongoing review. You must cooperate with the review process. • By approving an alternative benefit, we cannot guarantee you will get it in the future. • The decision to offer an alternative benefit is solely ours, and except as expressly provided in the agreement, we may withdraw it at any time and resume regular contract benefits. • If you sign the agreement, we will provide the agreed-upon alternative benefits for the stated time period (unless circumstances change). You may request an extension of the time period, but regular benefits will resume if we do not approve your request. • Our decision to offer or withdraw alternative benefits is not subject to OPM review under the disputed claims process.
24 hour nurse line	<p>For any of your health concerns, 24 hours a day, 7 days a week, you may call Health Information at (605) 333-4444 and talk with a registered nurse who will discuss treatment options and answer your health questions.</p>
Services for deaf and hearing impaired	<p>Hearing impaired members wishing to speak to Member Services may contact:</p> <ul style="list-style-type: none"> • Communication Services for the Deaf at (605) 362-3507 and ask for the head scheduler to arrange for an interpreter; • Community Resources for the Deaf at (605) 367-5759; or • For our hearing impaired members in surrounding states, a Relay System is available by calling 1-800-877-1113.
Interpreter Services	<p>The Member Services and Health Services Departments have access to interpreter services in order to coordinate services by phone. A member who speaks a foreign language may request a Plan representative contact Lutheran Social Services at 1-866-242-2447 or A-2-Z at 1-800-757-3775 in the language of their choice. Once an interpreter is contacted, a three-way conversation will take place between the member, Plan representative and the interpreter.</p>
Pregnancy programs and High risk pregnancies	<p>Individuals may contact the Healthy Pregnancy Program at 1-800-752-5863 to enroll.</p>
Centers of excellence	<p>We utilize the contracted Centers of Excellence Network for transplant services. Please contact us at (605) 328-6807 for any information needed.</p>
Services for visually impaired	<p>The Plan will make available upon request large print Handbooks for visually impaired members. Please contact our Member Services Department if you are in need of a large print copy or cassette/CD of the Handbook or other member materials.</p>
Account Management Tools	<p>Digital Health Plan is your online access to a variety of Member Services including:</p> <ul style="list-style-type: none"> • Finding a Participating Practitioner and/or Provider online; • Adding and removing dependents to your health plan;

- Ordering replacement ID Cards;
- Viewing authorization and referral requests;
- Viewing your personalized benefit plans;
- Updating personal information such as you name and address; and
- Viewing your claims status through an online Evidence of Benefits (EOB).

Digital Health Plan is available to you and every dependent on your plan. To access Digital Health Plan, each member must sign up and register with Digital Health Plan using a username and password that is chosen by the member. Health information is kept confidential and secure through this registration process. To register today, simply go to www.sanfordhealthplan.com and click on “Digital Health Plan.”

Section 5(h). Dental benefits

Important things you should keep in mind about these benefits:

- Please remember that all benefits are subject to the definitions, limitations, and exclusions in this brochure and are payable only when we determine they are medically necessary
- Plan dentists must provide or arrange your care.
- **Under High Option**, we have no calendar year deductible for In Network services.
- **Under Standard Option**, the calendar year deductible for Participating Providers is \$500 per person (\$1,000 per family). The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- **Under both High and Standard Options**, you must use Plan Providers in order to receive in-network benefit coverage.
- We cover hospitalization for dental procedures only when a non-dental physical impairment exists which makes hospitalization necessary to safeguard the health of the patient. See Section 5(c) for inpatient hospital benefits. We do not cover the dental procedure unless it is described below.
- Be sure to read Section 4, *Your costs for covered services*, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.
- **YOU OR YOUR PHYSICIAN MUST GET PRIOR APPROVAL FOR SOME DENTAL PROCEDURES.** Please refer to the prior approval information shown in Section 3 to be sure which services require prior approval.

Benefit Description	You Pay	
	High Option	Standard Option
Accidental injury benefit		
We cover restorative services and supplies necessary to promptly repair (but not replace) sound natural teeth (this does not include replacements including crowns, bridges or implants) as long as the patient was covered under the plan during the time of the injury or illness causing the damage and receives care within six (6) months of the occurrence. The need for these services must result from an accidental injury or cancer.	\$30 per specialist visit \$50 per outpatient surgery \$100 per day copay up to \$500 per inpatient admission	20% of charges for specialist visit or outpatient surgery \$100 per day copay up to \$500 per inpatient admission
Dental benefits		
<ul style="list-style-type: none"> • Dental services required for cancer that damages sound natural teeth • Associated radiology services 	\$30 per specialist visit \$50 per outpatient surgery \$100 per day copay up to \$500 per inpatient admission	\$30 per specialist visit \$50 per outpatient surgery \$100 per day copay up to \$500 per inpatient admission
<i>We have no other dental benefits.</i>	<i>All charges</i>	<i>All charges</i>

Section 5(i). Point of Service benefits

- All benefits are subject to the definitions, limitations and exclusions in this brochure and are payable only when we determine they are medically necessary.
- **Under High Option**, the calendar year deductible is \$500 per person and \$1,000 per family.
- **Under Standard Option**, the calendar year deductible for non-Participating Providers is \$1,000 per person and \$3,000 per family. The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.
- Be sure to read Section 4, Your costs for covered services, for valuable information about how cost sharing works. Also read Section 9 about coordinating benefits with other coverage, including with Medicare.

Facts about this Plan’s POS option

You may choose to obtain benefits covered by our POS: options from non-Plan doctors and hospitals whenever you need care, except for the benefits listed below under “What is not covered.” Benefits not covered under POS must be received by Plan doctors to be covered. When you obtain covered non-emergency medical treatment from a non-Plan doctor without authorization from us, you are subject to the deductibles, coinsurance and maximum benefit stated below.

What is covered:

- Medical Office Visits
- Preventive Health Services including Well Baby and Well Child Care (up to 6 years old), routine periodic preventive health exams, immunizations, allergy testing and treatment, and allergy serum
- Emergency Services (No deductible)
- X-Ray and Laboratory Services
- Acute Inpatient Hospital Services
- Maternity, Pregnancy and Newborn Care
- Inpatient Physician Services and Consultations
- Outpatient Hospital Services
- Outpatient Surgery
- Home Health Care
- Skilled Nursing Facility Service
- Mental Health Services
- Inpatient Chemical Dependency Services
- Inpatient Alcohol Treatment
- Durable Medical Equipment and Prosthetic Devices (Prior approval required for rentals or purchases over \$200)
- Orthopedic Appliances
- Outpatient Rehabilitative Therapy
- Oral Surgery and Other Dental Services
- Ambulance and other transportation services

What you pay for benefits:

Under **High and Standard Options**, you pay 40% of the allowed benefit after paying the deductible and any charges greater than the allowed benefit.

All participating providers are paid at the In-Network Benefit level and only the out-of-network doctor and/or facility charges are paid at the Out-of-Network POS level. Services obtained within or outside of the service area by non-Plan Participating Providers are eligible for coverage under POS.

How to obtain benefits:

To access POS benefits you may see the physician or obtain services at the facility of your choice. Benefits will be paid at 60% after the Out-of-Network deductible is met; you pay 40%, except for ambulance and other transportation services and outpatient substance abuse services which have a different coinsurance. We will need a claim from you, including a CPT code, date of service, diagnosis code, name of doctor or hospital, member's birthdate and identification number.

Submit your claims to: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110

Deductible	<p>The deductible is the amount that you must pay at the time services are received before we will pay for such services. The calendar year deductible applies to almost all benefits in this section. We added “(No deductible)” to show when the calendar year deductible does not apply.</p> <p>Under High Option, the calendar year deductible is \$500 per person and \$1,000 per family for Non-Participating Providers.</p> <p>Under Standard Option, the calendar year deductible for Non-Participating Providers is \$1,000 per person and \$3,000 per family.</p>
Coinsurance	<p>Coinsurance is the percentage of charges to be paid by you for services at the time such services are rendered. Our coinsurance for Point of Service benefits is 60%; you pay 40%, except for ambulance and other transportation services and outpatient substance abuse services which have a different coinsurance.</p> <p>The fee schedule is set at the 90th percentile of the standard Usual and Customary Rate (UCR) allowance for our region. You will be liable for your coinsurance percentage plus any charges in excess of the UCR allowance.</p>
Maximum benefit	<p>There is no lifetime maximum benefit under the POS plan.</p>
Catastrophic Protection Out-of-pocket maximum	<p>The catastrophic limit on your out-of-pocket Point of Service expenses per calendar year is \$10,000 for the individual and \$10,000 for the family (this does not apply to transplant services). Your out-of-pocket expenses under POS qualify for our catastrophic protection out-of-pocket maximum.</p>
Outpatient substance abuse benefits	<p>You pay 70% of our allowed benefit and any charges above the allowed \$30 benefit, after the deductible for all covered chemical dependency and alcohol treatment services.</p>
Ambulance and other transportation services	<p>Under High Option, you pay 20% of our allowed benefit and any charges above the allowed benefit, after the deductible, for all covered services. Prior approval is only required for non-emergency transportation.</p> <p>Under Standard Option, you pay 40% of our allowed benefit and any charges above the allowed benefit, after the deductible, for all covered services. Prior approval is only required for non-emergency transportation.</p>
Emergency services	<p>Medical emergency services as defined in Section 5(d) is always payable as an in-Plan benefit; there is a \$100 per day copay up to \$500 per inpatient admission, but the copay is waived if admitted.</p>
What is not covered	<ul style="list-style-type: none"> • Tobacco Treatment; • Services list as not covered in Section 5; • Chiropractic Services; • Transplants at Non-Participating Center of Excellence Facilities; • Custodial care; and • All other services not listed in the “What is covered” Section above.

Section 6. General exclusions – things we don't cover

The exclusions in this section apply to all benefits. There may be other exclusions and limitations listed in Section 5 of this brochure. Although we may list a specific service as a benefit, we will not cover it unless your Plan doctor determines it is medically necessary to prevent, diagnose, or treat your illness, disease, injury, or condition.

We do not cover the following:

- Services, drugs, or supplies you receive while you are not enrolled in this Plan;
- Services, drugs, or supplies not medically necessary;
- Services, drugs, or supplies not required according to accepted standards of medical, dental, or psychiatric practice;
- Experimental or investigational procedures, treatments, drugs or devices;
- Services, drugs, or supplies related to abortions, except when the life of the mother would be endangered if the fetus were carried to term, or when the pregnancy is the result of an act of rape or incest;
- Services, drugs, or supplies related to sex transformations;
- Services, drugs, or supplies you receive from a provider or facility barred from the FEHB Program;
- Services, drugs, or supplies you receive without charge while in active military service; or
- Health Care Services performed by any Provider who is a Member of the enrollee's immediate family, including any person normally residing in the member's home. This exclusion does not apply in those areas in which the immediate family member is the only Provider in the area.

Section 7. Filing a claim for covered services

When you see Plan physicians, receive services at Plan hospitals and facilities, or obtain your prescription drugs at Plan pharmacies, you will not have to file claims. Just present your identification card and pay your copayment, coinsurance, or deductible.

You will only need to file a claim when you receive emergency services from non-plan providers. Sometimes these providers bill us directly. Check with the provider. If you need to file the claim, here is the process:

Medical and hospital benefits

In most cases, providers and facilities file claims for you. Physicians must file on the form HCFA-1500, Health Insurance Claim Form. Your facility will file on the UB-92 form. For claims questions and assistance, call Member Services at (605) 328-6800 or toll free at 1-800-752-5863.

When you must file a claim – such as for services you received outside the Plan’s service area – submit it on the HCFA-1500 or a claim form that includes the information shown below. Bills and receipts should be itemized and show:

- Covered member’s name and ID number;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the services or supplies;
- Diagnosis;
- Type of each service or supply;
- The charge for each service or supply;
- A copy of the explanation of benefits, payments, or denial from any primary payer – such as the Medicare Summary Notice (MSN); and
- Receipts, if you paid for your services.

Submit your claims to: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110

Prescription drugs

Submit your claims to: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110

Other supplies or services

Submit your claims to: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110

Deadline for filing your claim

Send us all of the documents for your claim as soon as possible. You must submit the claim by December 31 of the year after the year you received the service, unless timely filing was prevented by administrative operations of Government or legal incapacity, provided the claim was submitted as soon as reasonably possible.

When we need more information

Please reply promptly when we ask for additional information. We may delay processing or deny benefits for your claim if you do not respond.

Section 8. The disputed claims process

Follow this Federal Employees Health Benefits Program disputed claims process if you disagree with our decision on your claim or request for services, drugs, or supplies – including a request for prior approval required by Section 3.

Step	Description
1	<p>Ask us in writing to reconsider our initial decision. You must:</p> <ul style="list-style-type: none"> a) Write to us within 6 months from the date of our decision; and b) Send your request to us at: Sanford Health Plan, PO Box 91110, Sioux Falls, SD 57109-1110; and c) Include a statement about why you believe our initial decision was wrong, based on specific benefit provisions in this brochure; and d) Include copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms.
2	<p>We have 30 days from the date we receive your request to:</p> <ul style="list-style-type: none"> a) Pay the claim (or, if applicable, arrange for the health care provider to give you the care); or b) Write to you and maintain our denial - go to step 4; or c) Ask you or your provider for more information. If we ask your provider, we will send you a copy of our request—go to step 3.
3	<p>You or your provider must send the information so that we receive it within 60 days of our request. We will then decide within 30 more days.</p> <p>If we do not receive the information within 60 days, we will decide within 30 days of the date the information was due. We will base our decision on the information we already have.</p> <p>We will write to you with our decision.</p>
4	<p>If you do not agree with our decision, you may ask OPM to review it.</p> <p>You must write to OPM within</p> <ul style="list-style-type: none"> • 90 days after the date of our letter upholding our initial decision; or • 120 days after you first wrote to us - if we did not answer that request in some way within 30 days; or • 120 days after we asked for additional information. <p>Write to OPM at: United States Office of Personnel Management, Insurance Services Programs, Health Insurance Group, 1900 E Street, NW, Washington, DC 20415-3630.</p> <p>Send OPM the following information:</p> <ul style="list-style-type: none"> • A statement about why you believe our decision was wrong, based on specific benefit provisions in this brochure; • Copies of documents that support your claim, such as physicians' letters, operative reports, bills, medical records, and explanation of benefits (EOB) forms; • Copies of all letters you sent to us about the claim; • Copies of all letters we sent to you about the claim; and • Your daytime phone number and the best time to call. <p>Note: If you want OPM to review more than one claim, you must clearly identify which documents apply to which claim.</p>

	<p>Note: You are the only person who has a right to file a disputed claim with OPM. Parties acting as your representative, such as medical providers, must include a copy of your specific written consent with the review request.</p> <p>Note: The above deadlines may be extended if you show that you were unable to meet the deadline because of reasons beyond your control.</p>
<p>5</p>	<p>OPM will review your disputed claim request and will use the information it collects from you and us to decide whether our decision is correct. OPM will send you a final decision within 60 days. There are no other administrative appeals.</p> <p>If you do not agree with OPM’s decision, your only recourse is to sue. If you decide to sue, you must file the suit against OPM in Federal court by December 31 of the third year after the year in which you received the disputed services, drugs, or supplies or from the year in which you were denied precertification or prior approval. This is the only deadline that may not be extended.</p> <p>OPM may disclose the information it collects during the review process to support their disputed claim decision. This information will become part of the court record.</p> <p>You may not sue until you have completed the disputed claims process. Further, Federal law governs your lawsuit, benefits, and payment of benefits. The Federal court will base its review on the record that was before OPM when OPM decided to uphold or overturn our decision. You may recover only the amount of benefits in dispute.</p>

Note: **If you have a serious or life threatening condition** (one that may cause permanent loss of bodily functions or death if not treated as soon as possible), and

- a) We haven’t responded yet to your initial request for care or preauthorization/prior approval, then call us at (605) 328-6807 and we will expedite our review; or
- b) We denied your initial request for care or preauthorization/prior approval, then:
 - If we expedite our review and maintain our denial, we will inform OPM so that they can give your claim expedited treatment too, or
 - You may call OPM’s Health Insurance Group 3 at (202) 606-0737 between 8 a.m. and 5 p.m. eastern time.

Section 9. Coordinating benefits with other coverage

When you have other health coverage

You must tell us if you or a covered family member has coverage under any other health plan or has automobile insurance that pays health care expenses without regard to fault. This is called “double coverage.”

When you have double coverage, one plan normally pays its benefits in full as the primary payer and the other plan pays a reduced benefit as the secondary payer. We, like other insurers, determine which coverage is primary according to the National Association of Insurance Commissioners’ guidelines.

When we are the primary payer, we will pay the benefits described in this brochure.

When we are the secondary payer, we will determine our allowance. After the primary plan pays, we will pay what is left of our allowance, up to our regular benefit. We will not pay more than our allowance. All plan benefits and visit limitations are taken into consideration even if benefits are coordinated. Visits and corresponding claims are denied once they go beyond plan maximum limits.

What is Medicare?

Medicare is a health insurance program for:

- People 65 years of age or older;
- Some people with disabilities under 65 years of age; and
- People with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant).

Medicare has four parts:

- Part A (Hospital Insurance). Most people do not have to pay for Part A. If you or your spouse worked for at least 10 years in Medicare-covered employment, you should be able to qualify for premium-free Part A insurance. (If you were a Federal employee at any time both before and during January 1983, you will receive credit for your Federal employment before January 1983.) Otherwise, if you are age 65 or older, you may be able to buy it. Contact 1-800-MEDICARE for more information.
- Part B (Medical Insurance). Most people pay monthly for Part B. Generally, Part B premiums are withheld from your monthly Social Security check or your retirement check.
- Part C (Medicare Advantage). You can enroll in a Medicare Advantage plan to get your Medicare benefits. We offer a Medicare Advantage plan. Please review the information on coordinating benefits with Medicare Advantage plans on the next page.
- Part D (Medicare prescription drug coverage). There is a monthly premium for Part D coverage. If you have limited savings and a low income, you may be eligible for Medicare’s Low-Income Benefits. For people with limited income and resources, extra help in paying for a Medicare prescription drug plan is available. Information regarding this program is available through the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778). Before enrolling in Medicare Part D, please review the important disclosure notice from us about the FEHB prescription drug coverage and Medicare. The notice is on the first inside page of this brochure. The notice will give you guidance on enrolling in Medicare Part D.

Should I enroll in Medicare?

The decision to enroll in Medicare is yours. We encourage you to apply for Medicare benefits 3 months before you turn age 65. It’s easy. Just call the Social Security Administration toll-free number 1-800-772-1213 to set up an appointment to apply. If you do not apply for one or more Parts of Medicare, you can still be covered under the FEHB Program.

If you can get premium-free Part A coverage, we advise you to enroll in it. Most Federal employees and annuitants are entitled to Medicare Part A at age 65 **without cost**. When you don't have to pay premiums for Medicare Part A, it makes good sense to obtain the coverage. It can reduce your out-of-pocket expenses as well as costs to the FEHB, which can help keep FEHB premiums down.

Everyone is charged a premium for Medicare Part B coverage. The Social Security Administration can provide you with premium and benefit information. Review the information and decide if it makes sense for you to buy the Medicare Part B coverage.

If you are eligible for Medicare, you may have choices in how you get your health care. Medicare Advantage is the term used to describe the various private health plan choices available to Medicare beneficiaries. The information in the next few pages shows how we coordinate benefits with Medicare, depending on whether you are in the Original Medicare Plan or a private Medicare Advantage plan. **(Please refer to page 58 for information about how we provide benefits when you are age 65 or older and do not have Medicare.)**

The Original Medicare Plan (Part A or Part B)

The Original Medicare Plan (Original Medicare) is available everywhere in the United States. It is the way everyone used to get Medicare benefits and is the way most people get their Medicare Part A and Part B benefits now. You may go to any doctor, specialist, or hospital that accepts Medicare. The Original Medicare Plan pays its share and you pay your share.

When you are enrolled in Original Medicare along with this Plan, you still need to follow the rules in this brochure for us to cover your care.

If your Plan physician does not participate in Medicare, you will have to file a claim with Medicare.

Claims process when you have the Original Medicare Plan – You will probably not need to file a claim form when you have both our Plan and the Original Medicare Plan.

When we are the primary payer, we process the claim first.

When Original Medicare is the primary payer, Medicare processes your claim first. In most cases, your claim will be coordinated automatically and we will then provide secondary benefits for covered charges. To find out if you need to do something to file your claim, call us at (605) 328-6800 or 1-800-752-5863 or see our website at www.sanfordhealthplan.com.

We waive some costs if the Original Medicare Plan is your primary payer – We will waive some out-of-pocket costs as follows:

- Medical services and supplies provided by physicians and other health care professionals.

We do not waive any costs if the Original Medicare Plan is your primary payer.

Medicare Advantage (Part C)

If you are eligible for Medicare, you may choose to enroll in and get your Medicare benefits from a Medicare Advantage plan. These are private health care choices (like HMOs and regional PPOs) in some areas of the country. To learn more about Medicare Advantage plans, contact Medicare at 1-800-MEDICARE (1-800-633-4227) or at www.medicare.gov.

If you enroll in a Medicare Advantage plan, the following options are available to you:

This Plan and another plan's Medicare Advantage plan: You may enroll in another plan's Medicare Advantage plan and also remain enrolled in our FEHB plan. We will still provide benefits when your Medicare Advantage plan is primary, even out of the Medicare Advantage plan's network and/or service area (if you use our Plan providers), but we will not waive any of our copayments, coinsurance, or deductibles. If you enroll in a Medicare Advantage plan, tell us. We will need to know whether you are in the Original Medicare Plan or in a Medicare Advantage plan so we can correctly coordinate benefits with Medicare.

Suspended FEHB coverage to enroll in a Medicare Advantage plan: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in a Medicare Advantage plan, eliminating your FEHB premium. (OPM does not contribute to your Medicare Advantage plan premium.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage or move out of the Medicare Advantage plan's service area.

Medicare prescription drug coverage (Part D)

When we are the primary payer, we process the claim first. If you enroll in Medicare Part D and we are the secondary payer, we will review claims for your prescription drug costs that are not covered by Medicare Part D and consider them for payment under the FEHB plan.

When you have Federal Employees Dental and Vision Insurance Plan (FEDVIP) coverage

Some FEHB plans already cover some dental and vision services. When you are covered by more than one vision/dental plan, coverage provided under your FEHB plan remains as your primary coverage. FEDVIP coverage pays secondary to that coverage. When you enroll in a dental and/or vision plan on BENEFEDS.com, you will be asked to provide information on your FEHB plan so that your plans can coordinate benefits. Providing your FEHB information may reduce your out-of-pocket cost.

Medicare always makes the final determination as to whether they are the primary payer. The following chart illustrates whether Medicare or this Plan should be the primary payer for you according to your employment status and other factors determined by Medicare. It is critical that you tell us if you or a covered family member has Medicare coverage so we can administer these requirements correctly. **(Having coverage under more than two health plans may change the order of benefits determined on this chart.)**

Primary Payer Chart		
A. When you - or your covered spouse - are age 65 or over and have Medicare and you...	The primary payer for the individual with Medicare is...	
	Medicare	This Plan
1) Have FEHB coverage on your own as an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through your spouse who is an annuitant	✓	
3) Have FEHB through your spouse who is an active employee		✓
4) Are a reemployed annuitant with the Federal government and your position is excluded from the FEHB (your employing office will know if this is the case) and you are not covered under FEHB through your spouse under #3 above	✓	
5) Are a reemployed annuitant with the Federal government and your position is not excluded from the FEHB (your employing office will know if this is the case) and...		
• You have FEHB coverage on your own or through your spouse who is also an active employee		✓
• You have FEHB coverage through your spouse who is an annuitant	✓	
6) Are a Federal judge who retired under title 28, U.S.C., or a Tax Court judge who retired under Section 7447 of title 26, U.S.C. (or if your covered spouse is this type of judge) and you are not covered under FEHB through your spouse under #3 above	✓	
7) Are enrolled in Part B only, regardless of your employment status	✓ for Part B services	✓ for other services
8) Are a Federal employee receiving Workers' Compensation disability benefits for six months or more	✓ *	
B. When you or a covered family member...		
1) Have Medicare solely based on end stage renal disease (ESRD) and...		
• It is within the first 30 months of eligibility for or entitlement to Medicare due to ESRD (30-month coordination period)		✓
• It is beyond the 30-month coordination period and you or a family member are still entitled to Medicare due to ESRD	✓	
2) Become eligible for Medicare due to ESRD while already a Medicare beneficiary and...		
• This Plan was the primary payer before eligibility due to ESRD (for 30 month coordination period)		✓
• Medicare was the primary payer before eligibility due to ESRD	✓	
3) Have Temporary Continuation of Coverage (TCC) and...		
• Medicare based on age and disability	✓	
• Medicare based on ESRD (for the 30 month coordination period)		✓
• Medicare based on ESRD (after the 30 month coordination period)	✓	
C. When either you or a covered family member are eligible for Medicare solely due to disability and you...		
1) Have FEHB coverage on your own as an active employee or through a family member who is an active employee		✓
2) Have FEHB coverage on your own as an annuitant or through a family member who is an annuitant	✓	
D. When you are covered under the FEHB Spouse Equity provision as a former spouse		
	✓	

*Workers' Compensation is primary for claims related to your condition under Workers' Compensation.

**TRICARE and
CHAMPVA**

TRICARE is the health care program for eligible dependents of military persons, and retirees of the military. TRICARE includes the CHAMPUS program. CHAMPVA provides health coverage to disabled Veterans and their eligible dependents. IF TRICARE or CHAMPVA and this Plan cover you, we pay first. See your TRICARE or CHAMPVA Health Benefits Advisor if you have questions about these programs.

Suspended FEHB coverage to enroll in TRICARE or CHAMPVA: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these programs, eliminating your FEHB premium. (OPM does not contribute to any applicable plan premiums.) For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under TRICARE or CHAMPVA.

Workers' Compensation

We do not cover services that:

- You need because of a workplace-related illness or injury that the Office of Workers' Compensation Programs (OWCP) or a similar Federal or State agency determines they must provide; or
- OWCP or a similar agency pays for through a third-party injury settlement or other similar proceeding that is based on a claim you filed under OWCP or similar laws.

Once OWCP or similar agency pays its maximum benefits for your treatment, we will cover your care.

Medicaid

When you have this Plan and Medicaid, we pay first.

Suspended FEHB coverage to enroll in Medicaid or a similar State-sponsored program of medical assistance: If you are an annuitant or former spouse, you can suspend your FEHB coverage to enroll in one of these State programs, eliminating your FEHB premium. For information on suspending your FEHB enrollment, contact your retirement office. If you later want to re-enroll in the FEHB Program, generally you may do so only at the next Open Season unless you involuntarily lose coverage under the State program.

**When other Government
agencies are responsible
for your care**

We do not cover services and supplies when a local, State, or Federal government agency directly or indirectly pays for them.

**When others are
responsible for injuries**

When you receive money to compensate you for medical or hospital care for injuries or illness caused by another person, you must reimburse us for any expenses we paid. However, we will cover the cost of treatment that exceeds the amount you received in the settlement.

If you do not seek damages you must agree to let us try. This is called subrogation. If you need more information, contact us for our subrogation procedures.

Section 10. Definitions of terms we use in this brochure

Calendar year	January 1 through Dec. 31 of the same year. For new enrollees, the calendar year begins on the effective date of their enrollment and ends on Dec. 31 of the same year.
Coinsurance	Coinsurance is the percentage of our allowance that you must pay for your care. You may also be responsible for additional amounts. See Section 4.
Copayment	A copayment is a fixed amount of money you pay when you receive covered services. See Section 4.
Cost-sharing	Cost-sharing is the general term used to refer to your out-of-pocket costs (e.g., deductible, coinsurance, and copayments) for the covered care you receive.
Covered services	Care we provide benefits for, as described in this brochure.
Custodial care	Care in which room, board, and other personal assistance services are provided, generally on a long-term basis and which does not include a medical component.
Deductible	A deductible is a fixed amount of covered expenses you must incur for certain covered services and supplies before we start paying benefits for those services. See Section 4.
Experimental or investigational service	Any healthcare services where the Healthcare service in question is either: 1) not recognized in accordance with generally accepted medical standards as being safe and effective for treatment of the condition in question, regardless of whether the service is authorized by law or used in testing or other studies; or 2) requires approval by any governmental authority and such approval has not been granted prior to the service being rendered.
Medical necessity	<p>Health care services that are appropriate, in terms or type, frequency, level, setting, and duration, to your diagnosis or condition, and diagnostic testing and preventative services. Medically necessary care must:</p> <ul style="list-style-type: none">• Be consistent with generally accepted standards of medical practice as recognized by the plan, as determined by health care providers in the same or similar general specialty as typically manages the condition, procedure, or treatment at issue; and• Help restore or maintain your health; or• Prevent deterioration of your condition; or• Prevent the likely onset of a health problem or detect an incipient problem; or• Not considered experimental or investigative. <p>For non-solid organ tissue transplants, the medical necessity requirement is considered satisfied whenever the patient meets the staging description and can safely tolerate the procedure.</p>
Plan allowance	<p>Plan allowance is the amount we use to determine our payment and your coinsurance for covered services. Plans determine their allowances in different ways. We determine our allowance as follows:</p> <ul style="list-style-type: none">• For in-network coverage the allowance is based on a percent of discounted charges that the Plan has negotiated with Participating Providers; in-network providers accept the plan allowance as payment in full.• For out-of-network providers the allowance is based on a percent of eligible reasonable and customary charges.
Us/We	Us and We refer to Sanford Health Plan
You	You refers to the enrollee and each covered family member.

Section 11. FEHB Facts

Coverage information

- **No pre-existing condition limitation**

We will not refuse to cover the treatment of a condition you had before you enrolled in this Plan solely because you had the condition before you enrolled.

- **Where you can get information about enrolling in the FEHB Program**

See www.opm.gov/insure/health for enrollment information as well as:

- Information on the FEHB Program and plans available to you
- A health plan comparison tool
- A list of agencies who participate in Employee Express
- A link to Employee Express
- Information on and links to other electronic enrollment systems

Also, your employing or retirement office can answer your questions, and give you a *Guide to Federal Benefits*, brochures for other plans, and other materials you need to make an informed decision about your FEHB coverage. These materials tell you:

- When you may change your enrollment;
- How you can cover your family members;
- What happens when you transfer to another Federal agency, go on leave without pay, enter military service, or retire;
- What happens when your enrollment ends; and
- When the next open season for enrollment begins.

We don't determine who is eligible for coverage and, in most cases, cannot change your enrollment status without information from your employing or retirement office.

- **Types of coverage available for you and your family**

Self Only coverage is for you alone. Self and Family coverage is for you, your spouse, and your unmarried dependent children under age 22, including any foster children or stepchildren your employing or retirement office authorizes coverage for. Under certain circumstances, you may also continue coverage for a disabled child 22 years of age or older who is incapable of self-support.

If you have a Self Only enrollment, you may change to a Self and Family enrollment if you marry, give birth, or add a child to your family. You may change your enrollment 31 days before to 60 days after that event. The Self and Family enrollment begins on the first day of the pay period in which the child is born or becomes an eligible family member. When you change to Self and Family because you marry, the change is effective on the first day of the pay period that begins after your employing office receives your enrollment form; benefits will not be available to your spouse until you marry.

Your employing or retirement office will **not** notify you when a family member is no longer eligible to receive benefits, nor will we. Please tell us immediately when family members are added or lose coverage for any reason, including divorce, annulment, or when your child under age 22 turns 22 or has a change in marital status, divorce, or when your child under age 22 marries.

If you or one of your family members is enrolled in one FEHB plan, that person may not be enrolled in or covered as a family member by another FEHB plan.

- **Children's Equity Act**

OPM has implemented the Federal Employees Health Benefits Children's Equity Act of 2000. This law mandates that you be enrolled for Self and Family coverage in the FEHB Program, if you are an employee subject to a court or administrative order requiring you to provide health benefits for your child(ren).

If this law applies to you, you must enroll for Self and Family coverage in a health plan that provides full benefits in the area where your children live or provide documentation to your employing office that you have obtained other health benefits coverage for your children. If you do not do so, your employing office will enroll you involuntarily as follows:

- If you have no FEHB coverage, your employing office will enroll you for Self and Family coverage in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option;
- If you have a Self Only enrollment in a fee-for-service plan or in an HMO that serves the area where your children live, your employing office will change your enrollment to Self and Family in the same option of the same plan; or
- If you are enrolled in an HMO that does not serve the area where the children live, your employing office will change your enrollment to Self and Family in the Blue Cross and Blue Shield Service Benefit Plan's Basic Option.

As long as the court/administrative order is in effect, and you have at least one child identified in the order who is still eligible under the FEHB Program, you cannot cancel your enrollment, change to Self Only, or change to a plan that doesn't serve the area in which your children live, unless you provide documentation that you have other coverage for the children. If the court/administrative order is still in effect when you retire, and you have at least one child still eligible for FEHB coverage, you must continue your FEHB coverage into retirement (if eligible) and cannot cancel your coverage, change to Self Only, or change to a plan that doesn't serve the area in which your children live as long as the court/administrative order is in effect. Contact your employing office for further information.

• **When benefits and premiums start**

The benefits in this brochure are effective January 1. If you joined this Plan during Open Season, your coverage begins on the first day of your first pay period that starts on or after January 1. **If you changed plans or plan options during Open Season and you receive care between January 1 and the effective date of coverage under your new plan or option, your claims will be paid according to the 2009 benefits of your old plan or option.** However, if your old plan left the FEHB Program at the end of the year, you are covered under that plan's 2008 benefits until the effective date of your coverage with your new plan. Annuitants' coverage and premiums begin on January 1. If you joined at any other time during the year, your employing office will tell you the effective date of coverage.

• **When you retire**

When you retire, you can usually stay in the FEHB Program. Generally, you must have been enrolled in the FEHB Program for the last five years of your Federal service. If you do not meet this requirement, you may be eligible for other forms of coverage, such as Temporary Continuation of Coverage (TCC).

When you lose benefits

• **When FEHB coverage ends**

You will receive an additional 31 days of coverage, for no additional premium, when:

- Your enrollment ends, unless you cancel your enrollment, or
- You are a family member no longer eligible for coverage.

Any person covered under the 31 day extension of coverage who is confined in a hospital or other institution for care or treatment on the 31st day of the temporary extension is entitled to continuation of the benefits of the Plan during the continuance of the confinement but not beyond the 60th day after the end of the 31 day temporary extension.

You may be eligible for spouse equity coverage or Temporary Continuation of Coverage (TCC), or a conversion policy (a non-FEHB individual policy.)

- **Upon divorce**

If you are divorced from a Federal employee or annuitant, you may not continue to get benefits under your former spouse's enrollment. This is the case even when the court has ordered your former spouse to provide health coverage for you. However, you may be eligible for your own FEHB coverage under either the spouse equity law or Temporary Continuation of Coverage (TCC).

If you are recently divorced or are anticipating a divorce, contact your ex-spouse's employing or retirement office to get RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, or other information about your coverage choices. You can also download the guide from OPM's Web site, www.opm.gov/insure.

- **Temporary Continuation of Coverage (TCC)**

If you leave Federal service, or if you lose coverage because you no longer qualify as a family member, you may be eligible for Temporary Continuation of Coverage (TCC). For example, you can receive TCC if you are not able to continue your FEHB enrollment after you retire, if you lose your Federal job, if you are a covered dependent child and you turn 22 or marry, etc.

You may not elect TCC if you are fired from your Federal job due to gross misconduct.

Enrolling in TCC. Get the RI 79-27, which describes TCC, and the RI 70-5, the *Guide to Federal Benefits for Temporary Continuation of Coverage and Former Spouse Enrollees*, from your employing or retirement office or from www.opm.gov/insure. It explains what you have to do to enroll.

- **Converting to individual coverage**

You may convert to a non-FEHB individual policy if:

- Your coverage under TCC or the spouse equity law ends (If you canceled your coverage or did not pay your premium, you cannot convert);
- You decided not to receive coverage under TCC or the spouse equity law; or
- You are not eligible for coverage under TCC or the spouse equity law.

If you leave Federal service, your employing office will notify you of your right to convert. You must apply in writing to us within 31 days after you receive this notice. However, if you are a family member who is losing coverage, the employing or retirement office will **not** notify you. You must apply in writing to us within 31 days after you are no longer eligible for coverage.

Your benefits and rates will differ from those under the FEHB Program; however, you will not have to answer questions about your health, and we will not impose a waiting period or limit your coverage due to pre-existing conditions.

- **Getting a Certificate of Group Health Plan Coverage**

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a Federal law that offers limited Federal protections for health coverage availability and continuity to people who lose employer group coverage. If you leave the FEHB Program, we will give you a Certificate of Group Health Plan Coverage that indicates how long you have been enrolled with us. You can use this certificate when getting health insurance or other health care coverage. Your new plan must reduce or eliminate waiting periods, limitations, or exclusions for health related conditions based on the information in the certificate, as long as you enroll within 63 days of losing coverage under this Plan. If you have been enrolled with us for less than 12 months, but were previously enrolled in other FEHB plans, you may also request a certificate from those plans.

For more information, get OPM pamphlet RI 79-27, *Temporary Continuation of Coverage (TCC) under the FEHB Program*. See also the FEHB Web site at www.opm.gov/insure/health; refer to the "TCC and HIPAA" frequently asked questions. These highlight HIPAA rules, such as the requirement that Federal employees must exhaust any TCC eligibility as one condition for guaranteed access to individual health coverage under HIPAA, and information about Federal and State agencies you can contact for more information.

Section 12. Three Federal Programs complement FEHB benefits

Important information

OPM wants to be sure you are aware of three Federal programs that complement the FEHB Program.

First, the **Federal Flexible Spending Account Program**, also known as FSAFEDS, lets you set aside pre-tax money from your salary to reimburse you for eligible dependent care and/or health care expenses. You pay less in taxes so you save money. The result can be a discount of 20% to more than 40% on services/products you routinely pay for out-of-pocket.

Second, the **Federal Employees Dental and Vision Insurance Program (FEDVIP)** provides comprehensive dental and vision insurance at competitive group rates. There are several plans from which to choose. Under FEDVIP you may choose self only, self plus one, or self and family coverage for yourself and any eligible dependents.

Third, the **Federal Long Term Care Insurance Program (FLTCIP)** can help cover long term care costs, which are not covered under the FEHB Program.

The Federal Flexible Spending Account Program – *FSAFEDS*

What is an FSA?

It is an account where you contribute money from your salary **BEFORE** taxes are withheld, then incur eligible expenses and get reimbursed. You pay less in taxes so you save money. **Annuitants are not eligible to enroll.**

There are three types of FSAs offered by FSAFEDS. Each type has a minimum annual election of \$250 and a maximum annual election of \$5,000.

- **Health Care FSA (HCFSA)** – Reimburses you for eligible health care expenses (such as copayments, deductibles, over-the-counter medications and products, vision and dental expenses, and much more) for you and your dependents, which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.
- **Limited Expense Health Care FSA (LEX HCFSA)** – Designed for employees enrolled in or covered by a High Deductible Health Plan with a Health Savings Account. Eligible expenses are limited to dental and vision care expenses for you and your dependents which are not covered or reimbursed by FEHBP or FEDVIP coverage or any other insurance.

Dependent Care FSA (DCFSA) – Reimburses you for eligible non-medical day care expenses for your child(ren) under age 13 and/or for any person you claim as a dependent on your Federal Income Tax return who is mentally or physically incapable of self-care. You (and your spouse if married) must be working, looking for work (income must be earned during the year), or attending school full-time to be eligible for a DCFSA.

Where can I get more information about FSAFEDS?

Visit www.FSAFEDS.com or call an FSAFEDS Benefits Counselor toll-free at 1-877-FSAFEDS (1-877-372-3337), Monday through Friday, 9 a.m. until 9 p.m., Eastern time. TTY: 1-800-952-0450.

The Federal Employees Dental and Vision Insurance Program – *FEDVIP*

Important Information

The Federal Employees Dental and Vision Insurance Program (FEDVIP) is a program, separate and different from the FEHB Program, established by the Federal Employee Dental and Vision Benefits Enhancement Act of 2004. This Program provides comprehensive dental and vision insurance at competitive group rates with no pre-existing condition limitations.

FEDVIP is available to eligible Federal and Postal Service employees, retirees, and their eligible family members on an enrollee-pay-all basis. Employee premiums are withheld from salary on a pre-tax basis.

Dental Insurance

Dental plans provide a comprehensive range of services, including all the following:

- Class A (Basic) services, which include oral examinations, prophylaxis, diagnostic evaluations, sealants and x-rays.
- Class B (Intermediate) services, which include restorative procedures such as fillings, prefabricated stainless steel crowns, periodontal scaling, tooth extractions, and denture adjustments.
- Class C (Major) services, which include endodontic services such as root canals, periodontal services such as gingivectomy, major restorative services such as crowns, oral surgery, bridges and prosthodontic services such as complete dentures.

Class D (Orthodontic) services with up to a 24-month waiting period

Vision Insurance

Vision plans provide comprehensive eye examinations and coverage for lenses, frames and contact lenses. Other benefits such as discounts on LASIK surgery may also be available.

Additional Information

You can find a comparison of the plans available and their premiums on the OPM website at www.opm.gov/insure/dentalvision. This site also provides links to each plan's website, where you can view detailed information about benefits and preferred providers.

How do I enroll?

You enroll on the Internet at www.BENEFEDS.com. For those without access to a computer, call 1-877-888-3337 (TTY number, 1-877- 889-5680).

The Federal Long Term Care Insurance Program – *FLTCIP***It's important protection**

The Federal Long Term Care Insurance Program (FLTCIP) can help you pay for the potentially high cost of long term care services, which are not covered by FEHB plans. Long term care is help you receive to perform activities of daily living – such as bathing or dressing yourself - or supervision you receive because of a severe cognitive impairment. To qualify for coverage under the FLTCIP, you must apply and pass a medical screening (called underwriting). Certain medical conditions, or combinations of conditions, will prevent some people from being approved for coverage. You must apply to know if you will be approved for enrollment. To request an Information Kit and application, call 1-800-LTC-FEDS (1-800-582-3337) (TTY 1-800-843-3557) or visit www.ltcfeds.com.

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Summary of benefits for the High Option of Sanford Health Plan - 2009

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.

Items subject to the calendar year deductible only apply when you use our Point of Services (POS) benefits.

High Option Benefits	You pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$20 primary care; \$30 specialist	17
Services provided by a hospital:		
• Inpatient	\$100 per day copay up to \$500 per admission	34
• Outpatient	\$50 per visit	35
• Outpatient Hospital Services	Nothing	35
• Outpatient Rehabilitative Services (cardiac rehab, physical, occupational, and speech therapies)	\$30 per outpatient visit Nothing per visit during covered inpatient admission	21
Emergency benefits:		
• In-area	\$100 per visit, waive if admitted	38
• Out-of-area	\$100 per visit, waive if admitted	38
Mental health and substance abuse treatment:	Regular cost sharing	40
Prescription drugs 30 day supply:		
• Generic drugs • Formulary brand name drugs • Non-formulary brand name drugs	\$15 copay \$30 copay \$50 copay Note: If there is no generic equivalent available, you will still have to pay the brand name copay	43
Dental care:	No benefit.	47
Vision care: Eye exams for children through age 17.	\$30 copay	22
Special features: Flexible benefits option, 24 hour nurse line, Services for deaf and hearing impaired, Services for visually impaired, Interpreter services, Pregnancy programs, and Centers of Excellence.	Nothing	45

High Option Benefits	You pay	Page
Point of Service benefits: Yes	Generally 40% of the allowed benefit after paying the deductible and any charges greater than the allowed benefit.	48
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$4,000/Self Only or \$4,000 Family enrollment per year. Any costs above reasonable and customary charges do not count towards this protection.	49

Summary of benefits for the Standard Option of Sanford Health Plan - 2009

- **Do not rely on this chart alone.** All benefits are provided in full unless indicated and are subject to the definitions, limitations, and exclusions in this brochure. On this page we summarize specific expenses we cover; for more detail, look inside.
- If you want to enroll or change your enrollment in this Plan, be sure to put the correct enrollment code from the cover on your enrollment form.
- We only cover services provided or arranged by Plan physicians, except in emergencies.
- Below, an asterisk (*) means the item is subject to the \$500/Self Only and \$1,000/Family calendar year deductible.

Standard Option Benefits	You Pay	Page
Medical services provided by physicians:		
Diagnostic and treatment services provided in the office	Office visit copay: \$25 primary care; \$25 specialist	17
Services provided by a hospital:		
• Inpatient	\$100 copay per day up to \$500 per admission*	34
• Outpatient	20% coinsurance*	35
• Outpatient Hospital Services	20% coinsurance*	35
• Outpatient Rehabilitative Services (cardiac rehab, physical, occupational, and speech therapies)	20% coinsurance* Nothing per visit during covered inpatient admission	21
Emergency benefits:		
• In-area	\$100 per visit, waive if admitted	38
• Out-of-area	\$100 per visit, waive if admitted	38
Mental health and substance abuse treatment:	Regular cost sharing*	40
Prescription drugs 30 day supply:		
• Generic drugs	\$15 copay	43
• Formulary brand name drugs	\$30 copay	
• Non-formulary brand name drugs	\$50 copay	
	Note: If there is no generic equivalent available, you will still have to pay the brand name copay.	
Dental care:	No benefit*	47
Vision care: Eye exams for children through age 17.	\$25 copay	22

Standard Option Benefits	You Pay	Page
Special features: Flexible benefits option, 24 hour nurse line, Services for the deaf and hearing impaired, Services for the visually impaired, Interpreter services, Healthy Pregnancy program, Centers of Excellence	Nothing	45
Point of Service benefits: Yes	Generally 40% of the allowed benefit after paying the deductible and any charges greater than the allowed benefit*	48
Protection against catastrophic costs (out-of-pocket maximum):	Nothing after \$3,000/Self Only or \$4,000 Family enrollment per year. Any costs above reasonable and customary charges do not count towards this protection.	49

2009 Rate Information for Sanford Health Plan

Non-Postal rates apply to most non-Postal employees. If you are in a special enrollment category, refer to the Guide to Federal Benefits for that category or contact the agency that maintains your health benefits enrollment.

Postal rates apply to career Postal Service employees. Most employees should refer to the Guide to Benefits *for Career United States Postal Service Employees*, RI 70-2, and to the rates shown below.

The rates shown below do not apply to *Postal Service Inspectors*, Office of Inspector General (OIG) employees and Postal Service Nurses. Rates for members of these groups are published in special Guides. Postal Service Inspectors and OIG employees should refer to the *Guide to Benefits for United States Postal Inspectors and Office of Inspector General Employees* (RI 70-2IN). Postal Service Nurses should refer to the *Guide to Benefits for United States Postal Nurses* (RI 70-2NU).

Postal rates do not apply to non-career postal employees, postal retirees, or associate members of any postal employee organization who are not career postal employees. Refer to the applicable Guide to Federal Benefits.

Type of Enrollment	Enrollment Code	Non-Postal Premium				Postal Premium	
		Biweekly		Monthly		Biweekly	
		Gov't Share	Your Share	Gov't Share	Your Share	USPS Share	Your Share

Central, Eastern South Dakota and the Rapid City area, and Northwestern Iowa

High Option Self Only	AU1	\$155.66	\$81.30	\$337.26	\$176.15	\$179.45	\$57.51
High Option Self and Family	AU2	\$352.56	\$192.70	\$763.88	\$417.52	\$406.42	\$138.84
Standard Option Self Only	AU4	\$155.66	\$70.00	\$337.26	\$151.67	\$179.45	\$46.21
Standard Option Self and Family	AU5	\$352.56	\$166.40	\$763.88	\$360.53	\$406.42	\$112.54