NORTH DAKOTA & SOUTH DAKOTA

The following outline is a summary of benefits for the 2017 plans. This information is only a summary of coverage. Please refer to the plan SBC and/or policy for full details.

Sanford Simplicity - INDIVIDUAL Plans in ND & SD (On & Off Exchange)

		Sanford Simplicity $1,250	Sanford Simplicity $3,500	Sanford Simplicity $4,000 (NEW) HSA/ HDHP	Sanford Simplicity $5,000 HSA/HDHP	Sanford Simplicity $6,000	Sanford Simplicity $7,150
Metal Level		*Gold*	*Silver*	*Silver*	*Bronze*	*Bronze*	*Catastrophic*
HSA Qualify (Yes or No)		No	No	YES	YES	No	No
In Network Medical Deductible	Individual	$1,250	$3,500	$4,000	$5,000	$6,000	$7,150
	Family	$2,500	$7,000	$8,000	$10,000	$12,000	$14,300
In Network Coinsurance-%	In Network Providers	20%	20%	0%	40%	40%	0%
In Network Maximum Out of Pocket-MOOP	Individual	$4,750	$7,150	$4,000	$6,550	$7,150	$7,150
	Family	$9,500	$14,300	$8,000	$13,100	$14,300	$14,300
Out of Network Medical Deductible	Individual	$2,500	$7,000	$8,000	$10,000	$12,000	$14,300
	Family	$5,000	$14,000	$16,000	$20,000	$24,000	$28,600
Out of Network Coinsurance-%	Out of Network Providers	40%	40%	50%	50%	50%	50%
Out of Network Maximum Out of Pocket-MOOP	Individual	$9,500	$14,300	$12,000	$13,100	$14,300	$21,450
	Family	$19,000	$28,600	$24,000	$26,200	$28,600	$42,900
Office Visits	Primary Visit	$20 Copay	$30 Copay	Deductible / Coinsurance	Deductible / Coinsurance	$45 (first 3 visits, then subject to deductible and coinsurance)	Deductible / Coinsurance (1st 3 Covered 100%)
	Specialty Visit	$50 Copay	$65 Copay	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
X-Ray and Lab Tests		Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
Preventive Care	Immunizations	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
	Routine Well Child Care	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
	Routine Adult Preventive Care	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Maternity Benefits	Inpatient Care	Deductible / Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
	Routine Maternity Care	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
	Routine Well Newborn Care	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
Inpatient Hospitalization Services		Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance

		Sanford Simplicity $1,250	Sanford Simplicity $3,500	Sanford Simplicity $4,000 (NEW) HSA/ HDHP	Sanford Simplicity $5,000 HSA/HDHP	Sanford Simplicity $6,000	Sanford Simplicity $7,150
Outpatient Surgery Physician/ Surgical Services		Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)		Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
Emergency / Urgent Care	Emergency Room Services	$250 (copay applies only after deductible)	$400 (copay applies only after deductible)	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
	Urgent Care Office Visit	$65 Copay	$75 Copay	Deductible / Coinsurance	Deductible / Coinsurance	$45 Copay	Deductible / Coinsurance
	Ambulance/ Emergency Transport	Deductible / Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
Chiropractic Care		$20 Copay	$30 Copay	Deductible / Coinsurance	Deductible / Coinsurance	$45 (first 3 visits, then subject to deductible and coinsurance)	Deductible / Coinsurance (1st 3 Covered 100%)
Substance Use Disorder Services	Office Visit	$20 Copay	$30 Copay	Deductible / Coinsurance	Deductible / Coinsurance	$45 (first 3 visits, then subject to deductible and coinsurance)	Deductible / Coinsurance (1st 3 Covered 100%)
	Inpatient	Deductible / Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
	Outpatient Other Services	Deductible / Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
Mental Health Care	Office Visit	$20 Copay	$30 Copay	Deductible / Coinsurance	Deductible / Coinsurance	$45 (first 3 visits, then subject to deductible and coinsurance)	Deductible / Coinsurance (1st 3 Covered 100%)
	Outpatient Other Services	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
	Inpatient	Deductible / Coinsurance	Deductible/ Coinsurance		Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
Pediatric Deductible		$0	$0	Integrated with Medical	$0	$0	Integrated with Medical
Pediatric Dental	Preventive/Basic	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%	Covered at 100%
	Major	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance
In Network Prescription Drug Deductible		Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical	Integrated with Medical
In Network Prescription Drugs	Generic Drugs	$10 Copay	$15 Copay	Deductible / Coinsurance	Deductible / Coinsurance	$40 Copay	Deductible / Coinsurance
	Formulary Brand Drugs	$30 Copay	$50 Copay	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
	Non-Formulary Brand Drugs	$75 Copay	$100 Copay	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance
	Specialty Drugs	30% Coinsurance	40% Coinsurance	Deductible / Coinsurance	Deductible / Coinsurance	Deductible/ Coinsurance	Deductible / Coinsurance

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