SANFORD HEALTH PLAN

Sanford Health Plan Large Group PY2024

Signature Series & Sanford TRUE Plans

NETWORK DESCRIPTIONS

BROAD NETWORK (Signature Series): Consists of over 25,000 providers within the Dakotas, Minnesota, and Iowa. The network expands beyond the Sanford Health care system, including access to Multiplan's nationwide network while traveling or for employees residing outside the Sanford Health Plan service area.

FOCUSED NETWORK (Sanford TRUE): Consists of providers, including access to our large care system of Sanford Health providers and facilities, plus some additional independent providers across the Dakotas, Minnesota, and Iowa.

DEDUCTIBLE*

$250	$300	$500	$750	$1000	$1250	$1500	$1750	$2000	$2500
$3000	$3500	$4000	$5000	$6000					

OUT-OF-POCKET MAXIMUM*

The Affordable Care Act annually publishes and allows a maximum OPM. SHP will not release a quote that exceeds the 2024 limits of $9,450 single & $18,900 family.

* Family Deductible are always 2x the Single Deductible amount.

1.5x, 2x, 2.5x, 3x, 4x, & 5x the deductible amounts for OPM limits.

COINSURANCE (IN-NETWORK) %

90/10%	80/20%	70/30%

OFFICE & ER VISITS

Copay: available office visit and ER cost share amounts below.

Flat Office Visit Copay:	$10	$15	$20	$25	$30	$35	$45	$50
	$55	Ded/Co*						
Flat Copay Note: * Deductible/Coinsurance: all office visits and ER services would be subject to deductible/coinsurance								
PCP/Specialty Office Visit Copay:	$10/35	$15/40	$20/45	$25/50	$30/55	$35/60	$45/70	$50/75
	$55/80							
Specialty Office Visit:	Ded/Co							
Emergency Room (ER) Copay:	$50	$75	$100	$150	$200	$250	$300	Ded/Co

PRESCRIPTION DRUG RIDER*

$0-5/20/35	$0-5/20/40	$0-5/25/40	$0-5/25/50	$0-5/30/50	$0-5/35/50
$0-10/20/35	$0-10/20/40	$0-10/25/40	$0-10/25/50	$0-10/30/50	$0-10/35/50
$0-15/25/40	$0-15/30/50	$0-15/35/50	$0-15/40/75	$0-15/50/75	
$0-5/50/100	$0-10/50/100	$0-15/50/100	$0-20/50/100	$0-25/50/100	
$0-10/30/75/10/100/200	$0-15/30/90/15/150/300	$0-20/40/80/20/150/300	$0-15/50/100/15/250/500	$0-25/50/100/25/250/500	

SBC & Formulary will reflect:	**$0-5/20/30**
Tier: 1 Generic	$0 copay – cost less than $6 $5 copay – cost $6 & above
Tier 2: Preferred brand	$20 copay
Tier 3: Non-preferred brand	$30 copay

SBC & Formulary will reflect:	**$0-10/30/75/10/100/200**
Tier: 1 Generic	$0 copay – cost less than $6 $10 copay – cost $6 & above
Tier 2: Preferred brand	$30 copay
Tier 3: Non-preferred brand	$75 copay
Tier 4: Generic Specialty	$10 copay
Tier 5: Preferred Specialty	$100 copay
Tier 6: Non-Preferred Specialty	$200 copay

*Refer to Pharmacy Benefits/Formulary to determine which benefit applies and for a list of drugs that may require certification (Prior Authorization).
Specialty must be dispensed from designated specialty pharmacy.

AVAILABLE RIDERS

Lab & X-Ray (available with flat and split copay's) Vision

HSA-QUALIFIED PLANS - EMBEDDED * Plans cover certain preventive drugs at a $5 copay

$3250 80% ($4250 OPM)	$3500 100%	$4000 80% ($8000 OPM)	$5000 80% ($8050 OPM)	$7000 100%
$3250 80% ($5250 OPM)	$3750 80% ($4750 OPM)	$4000 100%	$5000 100%	$7500 80% ($8050 OPM)
$3250 80% ($6500 OPM)	$3750 80% ($5750 OPM)	$4500 80% ($5500 OPM)	$6000 80% ($7000 OPM)	$7500 100%
$3250 100%	$3750 80% ($7500 OPM)	$4500 80% ($6500 OPM)	$6000 80% ($8050 OPM)	$8050 100%
$3500 80% ($4500 OPM)	$3750 100%	$4500 100%	$6000 100%	
$3500 80% ($5500 OPM)	$4000 80% ($5000 OPM)	$5000 80% ($6000 OPM)	$6900 100%	
$3500 80% ($7000 OPM)	$4000 80% ($6000 OPM)	$5000 80% ($7000 OPM)	$7000 80% ($8050 OPM)	